Last Name: Social Security Number: 462 – 59 – 9466 | H Group #

SECTION 6 — PREVIOUS COVERAGE INFORMATION

DO NOT COMPLETE IF APPLYING FOR HMO OR IN-HOSPITAL INDEMNITY COVERAGE

In order to receive credit for pre-existing condition waiting periods, you must provide information about the last 12 months of coverage (18 months if new/current coverage is self-funded) for you and any dependents listed. If you have a certificate of prior coverage, please attach a copy to this enrollment application. (If more than one plan was in effect, or if information is different for dependents, attach additional pages.) If Medicare, please complete the Medicare Coverage Information in Section 8.

List names of every individual covered:

Name of Primary Enrollee	Date of Birth	☒ Male ☐ Female	Relationship to Applicant	Group or Policy No.	ID Number
Ross Andrews	06/02/1982		☒ Self ☐ Spouse ☐ Dependent	550179	907658679

Employer's Name: Westlake Products

Name and address of other insurance company, TPA, HMO: Human

Employment Date 07 / 15 / 2009
Effective Date 11 / 10 / 2009
Will Coverage be Continued? ☐ Yes ☒ No
If No, Expected Cancel Date 01 / 18 / 2010

Type of Coverage: ☒ Health ☐ Dental

Type of Policy: ☒ Self ☐ Family ☐ Employee/Spouse ☐ Employee/Child

SECTION 7 — OTHER COVERAGE INFORMATION

Complete this section only if you or any of your dependents have other health and / or dental coverage **that will not be cancelled** when the coverage under this application becomes effective. **List names of each individual covered:**

Type of Coverage	Group Coverage	Name and Address of Other Health Care Company
☐ Health ☐ Dental	☐ Yes ☐ No	

Name of Policyholder	Date of Birth	☐ Male ☐ Female	Relationship to Applicant	Type of Policy
	/ /		☐ Self ☐ Spouse ☐ Dependent	☐ Self ☐ Two Person ☐ Family

ID Number	Employment Date	Effective Date of Coverage	Group or Policy Number	Employer's Name

SECTION 8 — MEDICARE COVERAGE INFORMATION

Name of person covered:

Medicare HIC# (from ID card):

☐ Medicare Part A (hospital)
Start Date:_____ End Date:_____
Month/Day/Year Month/Day/Year

☐ Medicare Part B (medical)
Start Date:_____ End Date:_____
Month/Day/Year Month/Day/Year

☐ Medicare Part D (prescription drugs)
Start Date:_____ End Date:_____
Month/Day/Year Month/Day/Year

If BCBSTX is not the Medicare Part D carrier, please provide name and address of the carrier:
Name: _____
Address: _____
City State

Check reason for Medicare eligibility: ☐ Entitled age ☐ Entitled disability ☐ End-stage renal disease ☐ Disability and current renal disease

Name of person covered:

Medicare HIC# (from ID card):

☐ Medicare Part A (hospital)
Start Date:_____ End Date:_____
Month/Day/Year Month/Day/Year

☐ Medicare Part B (medical)
Start Date:_____ End Date:_____
Month/Day/Year Month/Day/Year

☐ Medicare Part D (prescription drugs)
Start Date:_____ End Date:_____
Month/Day/Year Month/Day/Year

If BCBSTX is not the Medicare Part D carrier, please provide name and address of the carrier:
Name: _____
Address: _____
City State

Check reason for Medicare eligibility: ☐ Entitled age ☐ Entitled disability ☐ End-stage renal disease ☐ Disability and current renal disease

SECTION 9 — DISABLED DEPENDENT

Name of disabled dependent

Nature of disability

Has disability been diagnosed as permanent? ☐ Yes ☐ No If temporary, how long is dependent expected to remain disabled? _____

Is dependent unable to work due to the disability? ☐ Yes ☐ No If disabled child is over the dependent age limit of your employer's plan, please attach a completed Dependent Child's Statement of Disability form.

SECTION 10 — DECLINATION OF HEALTH COVERAGE

This is to certify the available coverage has been explained to me. I have been given the opportunity to apply for the coverage offered to me and my eligible dependents and have voluntarily elected to decline the coverage as indicated below. If I desire to apply for coverage at a later date, I understand there may be a delay in the effective date of the coverage as well as a pre-existing condition waiting period.

Employee _____
Reason for declining: ☐ Other Group Coverage ☐ Medicare ☐ Medicaid ☐ Other, explain: _____

Spouse _____
Reason for declining: ☐ Other Group Coverage ☐ Medicare ☐ Medicaid ☐ Other, explain: _____

Child(ren) _____
Reason for declining: ☐ Other Group Coverage ☐ Medicare ☐ Medicaid ☐ Other, explain: _____

SECTION 11 — COVERAGE CONDITIONS

- I am an employee of the Employer named in this Enrollment Application. I am eligible to participate in the coverage(s) afforded by my Employer's plan, which is either underwritten or administered by Blue Cross and Blue Shield of Texas (BCBSTX) or Fort Dearborn Life Insurance Company (FDL). On behalf of myself and any dependents listed on this Enrollment Application, I apply for those coverage(s) for which I am eligible. I state that the information given on this Enrollment Application is true and correct. I understand and agree that any incorrect statements material to the risk and knowingly made by me will invalidate my coverage(s).
- Only those coverage(s) and amounts for which I am eligible will be available to me. I understand that if this Enrollment Application is accepted, the coverage(s) will become effective in accordance with the provisions of the Contracts(s)/Plan(s).
- I understand that the Health coverage for which I am applying may have a pre-existing condition exclusion waiting period.
- I agree that my Employer acts as my agent. I authorize necessary payroll deduction by my Employer, if any, to cover the cost of my coverage(s).
- I understand that my participation in the coverage(s) is subject to any future amendment. I also understand that all notices given to my Employer are binding upon me.

Applicant's Signature _____ Date 23 Jan 2010