



# TEXAS ASSOCIATION of COUNTIES HEALTH AND EMPLOYEE BENEFITS POOL

## Enrollment Application/Change Form

Office Personnel Use Only

Processed in OASYS:

On: \_\_\_\_\_ By: \_\_\_\_\_

Employer Name: \_\_\_\_\_ Group Number: \_\_\_\_\_

### SECTION 1 – EMPLOYEE INFORMATION

Social Security	Date of Hire (MM/DD/YYYY)	First Name	MI	Last Name	Suffix
Birth Date (MM/DD/YYYY)	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married	Employee Type: <input type="checkbox"/> Full-Time Active <input type="checkbox"/> Appointed or Elected Official		
Mailing Address / Street – Apt No. / City/ State/ Zip Code					
Home Phone	Cell Phone	Work Phone	Email Address		

### SECTION 2 – ENROLLMENT / CHANGES CANCELLATION EVENTS

<input type="checkbox"/> New Enrollee      Effective Date : ___/___/___ <input type="checkbox"/> Retirement      Effective Date : ___/___/___ <input type="checkbox"/> Open Enrollment      Effective Date : ___/___/___ <input type="checkbox"/> Beneficiary Change ( <i>Complete Section 5</i> ) <input type="checkbox"/> Name/Address Change <input type="checkbox"/> Add Dependent      Event Date: ___/___/___ Status Change: <i>Select event below to add dependent</i> <input type="checkbox"/> Birth/Adoption/Guardianship <input type="checkbox"/> Marriage <input type="checkbox"/> Court Order (QMCSO) <input type="checkbox"/> Dependent Loses Other Coverage <input type="checkbox"/> Other (Explain): _____	<input type="checkbox"/> Terminate Employee (Last date worked ___/___/___) <input type="checkbox"/> Cancel/Waive Employee Coverage      Effective Date : ___/___/___ <input type="checkbox"/> Health <input type="checkbox"/> Basic Life and AD&D <input type="checkbox"/> Cancel Dependent: Health <u>List dependents to be cancelled in Section 4 &amp; Select Status Change Event Below</u> Status Change:      Event Date: ___/___/___ <input type="checkbox"/> Death <input type="checkbox"/> Dependent Gains Other Coverage <input type="checkbox"/> Dependent Drops Coverage (Only allowed for participants not enrolled in a cafeteria plan.) <input type="checkbox"/> Divorce
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### SECTION 3 – COVERAGE ELECTIONS - Check all that apply

<b>Medical PPO Plan</b>	<input type="checkbox"/> Employee Only <input type="checkbox"/> Employee + 1 Child <input type="checkbox"/> Employee + Spouse <input type="checkbox"/> Employee + Children <input type="checkbox"/> Employee + Family  <i>(Complete Section 4 to add dependents)</i>	<input type="checkbox"/> Waive Medical Coverage <i>(Complete Section 9)</i>
<b>Life Plan</b> VOYA Financial	<input type="checkbox"/> Employer Paid Basic Life and AD&D \$ _____ <i>(Complete Sections 5)</i>	<input type="checkbox"/> Waive Basic Life and AD&D



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Group No.

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Section No.

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Social Security No.

**SECTION 4 – DEPENDENT INFORMATION** - Please fill out all dependents for medical coverage.

	Coverage Type	Relationship	Social Security No.	First Name	MI	Last Name	Date of Birth	Gender
<input type="checkbox"/> Add <input type="checkbox"/> Drop	Medical	Spouse						<input type="checkbox"/> Male <input type="checkbox"/> Female
<input type="checkbox"/> Add <input type="checkbox"/> Drop	Medical	Child/Other Eligible Dep.						<input type="checkbox"/> Male <input type="checkbox"/> Female
<input type="checkbox"/> Add <input type="checkbox"/> Drop	Medical	Child/Other Eligible Dep.						<input type="checkbox"/> Male <input type="checkbox"/> Female
<input type="checkbox"/> Add <input type="checkbox"/> Drop	Medical	Child/Other Eligible Dep.						<input type="checkbox"/> Male <input type="checkbox"/> Female
<input type="checkbox"/> Add <input type="checkbox"/> Drop	Medical	Child/Other Eligible Dep.						<input type="checkbox"/> Male <input type="checkbox"/> Female

**SECTION 5 - BENEFICIARY INFORMATION** – Designate your beneficiary (ies) below. (REQUIRED)

**BENEFICIARY DESIGNATION:** (For Employee Only: Must Be Completed if you have applied for Life or AD&D insurance.) If two or more primary beneficiaries are named, and you do not list benefit percentages, proceeds will be paid in equal shares to the named primary beneficiaries who survive you. If no primary beneficiary survives you, proceeds will be paid to the contingent beneficiary(ies). If you list benefit percentages, the total must equal 100%. *Note: The employee is the beneficiary for any Dependent insurance coverage.*

New       Change

	Social Security No	Name of Beneficiary	Date of Birth	Relationship	Percentage
<input type="checkbox"/> Primary <input type="checkbox"/> Contingent					%
<input type="checkbox"/> Primary <input type="checkbox"/> Contingent					%
<input type="checkbox"/> Primary <input type="checkbox"/> Contingent					%
<input type="checkbox"/> Primary <input type="checkbox"/> Contingent					%

**SECTION 6 – DISABLED DEPENDENT** (If applicable)

Name of Disabled Dependent: \_\_\_\_\_ Nature of Disability: \_\_\_\_\_

*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 7 – OTHER COVERAGE INFORMATION** (If applicable)

For Coordination of Benefits (COB), complete this section only if you or any of your covered dependents have health and/or dental coverage that will not be cancelled when the coverage under this enrollment becomes effective.

Group Coverage <input type="checkbox"/> Yes <input type="checkbox"/> No	Name and Address of Other Insurance Carrier		Effective Date (MM/DD/YYYY)	Type of Policy: <input type="checkbox"/> Employee Only <input type="checkbox"/> Employee / Spouse <input type="checkbox"/> Employee / Child(ren) <input type="checkbox"/> Employee / Family	
Name of Policyholder		Date of Birth (MM/DD/YYYY)	<input type="checkbox"/> Male <input type="checkbox"/> Female	Relationship to Applicant: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent	
Employer's Name	Employment Date (MM/DD/YYYY)	Health Group No.	Health ID No.	Dental Group No:	Dental ID No

**SECTION 8 – MEDICARE COVERAGE INFORMATION** Complete this section (If applicable)

Name of person covered	Medicare HIC No. (from Medicare Card)	<input type="checkbox"/> Medicare A(Hospital) Effective Date: _____ <input type="checkbox"/> Medicare B (Medical) Effective Date: _____ <input type="checkbox"/> Medicare D (Rx) Effective Date: _____ RX Carrier: _____
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Please indicate reason for Medicare Eligibility:  Entitled Age  Entitled Disability  End-Stage Renal Disease  Disability & Current Renal Disease



Group No.

Section No.

Social Security No.

**SECTION 9 – DECLINATION OF COVERAGE** Complete this section (if applicable)

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 dependent(s) 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.

Name  Employee Reason for Declining Health:  Other Group/Individual Health Coverage  Medicare  Medicaid  
 I am not enrolled in any Health insurance plan, but do not want this coverage.  Other \_\_\_\_\_

Name  Spouse Reason for Declining Health:  Other Group/Individual Health Coverage  Medicare  Medicaid  
 I am not enrolled in any Health insurance plan, but do not want this coverage.  Other \_\_\_\_\_

Name  Child(ren) Reason for Declining Health:  Other Group/Individual Health Coverage  Medicare  Medicaid  
 I am not enrolled in any Health insurance plan, but do not want this coverage.  Other \_\_\_\_\_

**SECTION 10 – COVERAGE CONDITIONS AND AUTHORIZATION**

- 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 Texas Association of Counties Health and Employee Benefits Pool (TACHEBP) / Blue Cross and Blue Shield of Texas (BCBSTX) or Voya Financial Underwritten by ReliaStar Life Insurance Company, a member of the Voya family of companies. 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 intentional misrepresentation of a material fact 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 my participation in the coverage(s) is subject to any future amendment. I also understand that all notices given to my Employer are applicable to me.
- I understand my coverage begins on the effective date assigned by my employer, provided I am actively at work.
- I also understand that evidence of insurability may be required for additional life coverage to become effective.

Applicant's Signature \_\_\_\_\_ Date \_\_\_\_\_

