



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"/> 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"/> Voluntary Vision <input type="checkbox"/> Cancel Dependent: <input type="checkbox"/> Health <input type="checkbox"/> Voluntary Vision <u>List dependents to be cancelled in Section 4 & 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

Medical PPO Plan	<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 (Complete Section 4 to add dependents)	<input type="checkbox"/> Waive Medical Coverage (Complete Section 8)
Voluntary Vision Plan Dearborn National	<input type="checkbox"/> Employee Only <input type="checkbox"/> Employee + Children <input type="checkbox"/> Employee + Spouse <input type="checkbox"/> Employee + Family (Complete Section 4 to add dependents)	<input type="checkbox"/> Waive Vision Coverage

SECTION 4 – DEPENDENT INFORMATION - Please fill out all dependents for all coverages that apply.

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



Group No.

Section No.

Social Security No.

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

SECTION 5 – 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 6 – 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 7 – 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**SECTION 8 – 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 <input type="checkbox"/> Employee	Reason for Declining Health: <input type="checkbox"/> Other Group/Individual Health Coverage <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> I am not enrolled in any Health insurance plan, but do not want this coverage. <input type="checkbox"/> Other _____
Name <input type="checkbox"/> Spouse	Reason for Declining Health: <input type="checkbox"/> Other Group/Individual Health Coverage <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> I am not enrolled in any Health insurance plan, but do not want this coverage. <input type="checkbox"/> Other _____
Name <input type="checkbox"/> Child(ren)	Reason for Declining Health: <input type="checkbox"/> Other Group/Individual Health Coverage <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> I am not enrolled in any Health insurance plan, but do not want this coverage. <input type="checkbox"/> Other _____

SECTION 9 – 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). 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 Contract(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 _____

