Benefit Election Form

With this form, you'll choose insurance coverage for yourself & family. If you waive (decline) medical coverage for yourself or your dependents now, you will NOT be able to get coverage until the next open enrollment period or within 31 days of a status change (e.g., death, birth, marriage, etc.) and there may be extensive waiting periods. All amounts are based on payroll frequency calculations and will be deducted from your pay.

Section 125 – Pre-tax Payroll Deduction of Premiums

Any Medical, Dental, Vision insurance premiums and HSA contributions you elect for the next plan year will be treated as pre-tax premiums according to Section 125. If you do not want them treated this way, you must contact the Human Resources Department before your effective date.

Important Information on the Section 125 – Flexible Benefit Plan

If you elect any of the Section 125 – Flexible Benefit Plan options, please read and sign the following terms and conditions. In choosing any of the Section 125 options, I understand that:

1. **I cannot change or revoke this benefit election or salary reduction** before the next plan year, unless I have a significant change in benefits or cost of coverage, or a change in status (including marriage, divorce, death of a spouse or a child, birth or adoption of a child, termination or commencement of employment of a spouse, change in my or my spouse's employment status from full-time to part-time or from part-time to full-time, my spouse or I take an unpaid leave of absence, dependent becomes eligible/ineligible for coverage due to age, a change in worksite or residence of employee, spouse, or dependent that would affect the availability or current elected benefits) or other such events as the Plan Administrator determines will permit a change or revocation of an election.

2. If my required contributions for the elected benefits are increased or decreased while this agreement remains in effect, my salary reduction will automatically be adjusted to reflect that increase or decrease.

3. **Before the plan year ends, I will be offered the opportunity to change my benefit election(s) for the following Plan Year.** If I **do not** complete and return a new election form at that time, my previous insured benefit choices will continue in effect for the new Plan Year **but not my non-insured benefits**. In addition, this salary reduction agreement will continue by its terms in the amount of the required contribution for the insured benefit option.

4. The Plan Administrator may reduce or cancel the amount of my salary reduction or otherwise modify this agreement in accordance with the Section 125 – Flexible Benefit Plan if he believes it is advisable to satisfy certain provisions of the Internal Revenue code or other applicable law.

5. The reduction in my salary under this agreement is in addition to any reductions under other agreements or benefit plans maintained by my employer.

This agreement is subject to the terms of the employer's Section 125 – Flexible Benefits Plan, as amended from time to time, and shall be governed by and construed in accordance with applicable laws. This agreement revokes any prior election and salary reduction agreement relating to the Section 125 – Premium Conversion Plan.

ENROLLMENT APPLICATION/CHANGE FORM

BlueCross BlueShield of Texas

Dearborn National

Group # | Section # | Social Security #

Account # | Category

Please Note: If your group offers a Consumer Choice health plan you have the option to choose a Consumer Choice of Benefits Health Insurance Plan or Consumer Choice of Benefits Health Maintenance Organization health care plan that, either in whole or in part, does not provide state-mandated health benefits normally required in accident and sickness insurance policies or evidences of coverage in Texas. This standard health benefit plan may provide a more affordable health insurance policy or health plan for you, although, at the same time, it may provide you with fewer health benefits than those normally included as state-mandated health benefits in policies or evidences of coverage in Texas. If you choose this standard health benefit plan, please consult with your insurance agent to discover which state-mandated health benefits are excluded in this policy or evidence of coverage.

SECTION 1 — ENROLLMENT EVENTS

PLEASE CHECK ALL THAT APPLY – IF YOU ARE DECLINING COVERAGE, COMPLETE SECTIONS 2, 8 AND 9 ONLY

☐ **New Enrollee** ☐ **Add Dependent** ☐ **Open Enrollment** ☐ **Other Changes**

Are you applying as a result of a Special Enrollment Event?

☐ **No** ☐ **Yes, Event Date:** ____ / ____ / ____

Event: ☐ New Hire ☐ Marriage* ☐ Birth

☐ Adoption or Suit for Adoption (provide legal documents)

☐ Court Order (provide court order or decree)

☐ Loss of Other Coverage

☐ Other (explain): _____

Effective Date of Benefits: ____ / ____ / ____ ☐ **Completion of Other Eligibility Requirements**

☐ **Cancel Enrollee** ☐ **Cancel Dependent**

Cancel Coverage: ☐ Health ☐ Dental

☐ Term Life ☐ Dependent Life

☐ Short-Term Disability ☐ Long-Term Disability

List names of those canceling in Section 4 below

Event: ☐ Divorce** ☐ Death

☐ Terminated Employment ☐ Other

Indicate Event Date: ____ / ____ / ____

SECTION 2 — PLEASE TELL US ABOUT YOURSELF

COMPLETE EVEN IF DECLINING COVERAGE

Last Name	First Name	MI (opt)	Suffix	Birth Date (MM/DD/YYYY)	Social Security #
					– –

Mailing Address - Street - Apt #	City	State	ZIP code

Email Address	☐ Male ☐ Female	Home/Cell Phone #

Name of Employer	Job Title	Business Phone #	Employment Date (MM/DD/YYYY)	Do you usually work at least 30 hours a week for this employer? ☐ Yes ☐ No
HAROS				

Eligibility Status: ☐ Active Employee ☐ Retired Employee - Date of Retirement: _____ ☐ COBRA Continuation

☐ State Continuation of Group Coverage (insured plans only) ☐ Dependent State Continuation of Group Coverage (insured plans only)

SECTION 3 — SELECT YOUR COVERAGE

PLEASE CHECK ALL THAT APPLY

Large Group Plans (more than 50 Employees)

Health Coverage (select one)	**Who is covered for health? (select one)**	**Dental Coverage**	**Who is covered for dental? (select one)**
☐ Blue Choice PPO℠	☐ Employee Only	☐ Yes	☐ Employee Only
PPO MM4522 | PPO MMB422 | HSA MMH322	☐ Employee/Spouse	☐ No	☐ Employee/Child(ren)
Plan # _____	☐ Employee/Child(ren)	Plan # (required)	☐ Family
	☐ Family	_____	☐ I am not applying for Dental coverage
	☐ I am not applying for Health coverage		

Primary Language: _____ ☐ Check here to request a Spanish HMO Member Handbook

Do you have a disability affecting your ability to communicate or read? ☐ Yes ☐ No

If "Yes," describe special communication materials needed: _____

Group Term Life, Accidental Death and Dismemberment (AD&D) and Disability Insurance through Dearborn National®^

☐ I am not applying for Group Term Life, AD&D or Disability Insurance coverage

Employee Occupation/Job Title: _____ Wage Rate $_____ per ☐ hour ☐ week ☐ month ☐ year

Group Basic Term Life and AD&D	☐ I do not apply	☐ I do apply	Amount $_____
Group Dependents' Life	☐ I do not apply	☐ I do apply	
Group Supplemental Life	☐ I do not apply	☐ I do apply	
Employee Election: $_____	Spouse Election: $_____		Child Election: $_____
Short-Term Disability	☐ I do not apply	☐ I do apply	
Long-Term Disability	☐ I do not apply	☐ I do apply	

	First Name	Initial	Last Name	Relationship	Birth Date (MM/DD/YYYY)	Social Security #
Primary Beneficiary						– –
Contingent Beneficiary						– –

* The term "marriage" includes legal marriage and the establishment of a domestic partnership (coverage subject to your employer's plan).

** The term "divorce" includes legal divorce and the comparable termination of a domestic partnership (coverage subject to your employer's plan).

*** The use of the term "spouse" includes a legal spouse. It also includes a party to a domestic partnership (coverage subject to your employer's plan).

^ Products and services marketed under the Dearborn National™ brand and the star logo are underwritten and/or provided by Dearborn National® Life Insurance Company (Downers Grove, Illinois) in all states (excluding New York), the District of Columbia, the United States Virgin Islands, the British Virgin Islands, Guam and Puerto Rico. Dearborn National® Life Insurance Company does not provide Blue Cross and Blue Shield of Texas products and services, and is a separate company.

Last Name: Social Security #: — — Group #

SECTION 4 — COVERAGE OPTIONS

PLEASE COMPLETE ALL AREAS THAT APPLY. PCP SELECTION IS REQUIRED FOR BLUE ADVANTAGE, BLUE PREMIER AND BLUE ESSENTIALS PLANS. PCP SELECTION IS NOT REQUIRED FOR BLUE PREMIER ACCESS AND BLUE ESSENTIALS ACCESS PLANS.

Employee/Enrollee's Name	PCP Name	PCP #	New Patient? ☐ Y ☐ N	HMO OB/GYN Name (optional)	HMO OB/GYN #
Dependent's Name ☐ Husband ☐ Wife ☐ Domestic Partner	Dependent's PCP Name	PCP #	New Patient? ☐ Y ☐ N	HMO OB/GYN Name (optional)	HMO OB/GYN #
Dependent's Social Security # – –	Birth Date (MM/DD/YYYY)	Address (if different) - # and Street Address	City	State	ZIP code

Dependent's Name ☐ Son ☐ Daughter ☐ Other Eligible Dependent	Dependent's Social Security # – –	Dependent's PCP Name	PCP #	New Patient? ☐ Y ☐ N	HMO OB/GYN Name (optional)	HMO OB/GYN #
Birth Date (MM/DD/YYYY)	Home Address (If different) Street/City/State/ZIP code	Is this dependent a natural child, stepchild, foster child, adopted child, or a child in suit for adoption? ☐ Y ☐ N	If not your eligible natural child, stepchild, foster child, adopted child or child in suit for adoption, are you (or your spouse) responsible for this dependent? ☐ Y ☐ N			
Dependent's Name ☐ Son ☐ Daughter ☐ Other Eligible Dependent	Dependent's Social Security # – –	Dependent's PCP Name	PCP #	New Patient? ☐ Y ☐ N	HMO OB/GYN Name (optional)	HMO OB/GYN #
Birth Date (MM/DD/YYYY)	Home Address (If different) Street/City/State/ZIP code	Is this dependent a natural child, stepchild, foster child, adopted child, or a child in suit for adoption? ☐ Y ☐ N	If not your eligible natural child, stepchild, foster child, adopted child or child in suit for adoption, are you (or your spouse) responsible for this dependent? ☐ Y ☐ N			
Dependent's Name ☐ Son ☐ Daughter ☐ Other Eligible Dependent	Dependent's Social Security # – –	Dependent's PCP Name	PCP #	New Patient? ☐ Y ☐ N	HMO OB/GYN Name (optional)	HMO OB/GYN #
Birth Date (MM/DD/YYYY)	Home Address (If different) Street/City/State/ZIP code	Is this dependent a natural child, stepchild, foster child, adopted child, or a child in suit for adoption? ☐ Y ☐ N	If not your eligible natural child, stepchild, foster child, adopted child or child in suit for adoption, are you (or your spouse) responsible for this dependent? ☐ Y ☐ N			

SECTION 5 — DISABLED DEPENDENT

PLEASE COMPLETE IF APPLICABLE

Name of Disabled Dependent	Nature of Disability
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

PLEASE COMPLETE ALL AREAS THAT APPLY

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

Group Coverage ☐ Yes ☐ No	Individual Coverage ☐ Yes ☐ No	Name and Address of Other Insurance Carrier	Effective Date (MM/DD/YYYY)	Type of Policy ☐ Employee Only ☐ Employee/Spouse ☐ Employee/Child(ren) ☐ Family

Name of Policyholder	Birth Date (MM/DD/YYYY)	☐ Male ☐ Female	Relationship to Applicant ☐ Self ☐ Spouse ☐ Dependent

Employer's Name	Employment Date (MM/DD/YYYY)	Health Group #	Health ID #	Dental Group #	Dental ID #

SECTION 7 — MEDICARE COVERAGE INFORMATION

PLEASE COMPLETE IF APPLICABLE

Name of person covered:	Medicare A (Hospital) Effective Date: _____ End Date: _____ Medicare B (Medical) Effective Date: _____ End Date: _____ Medicare D (Drug) Effective Date: _____ End Date: _____ Medicare D (Drug) Carrier: _____	Medicare HIC # (From Medicare Card)
Please indicate reason for Medicare Eligibility: ☐ Entitled Age ☐ Entitled Disability ☐ End-Stage Renal Disease ☐ Disability and Current Renal Disease		
Name of person covered:	Medicare A (Hospital) Effective Date: _____ End Date: _____ Medicare B (Medical) Effective Date: _____ End Date: _____ Medicare D (Drug) Effective Date: _____ End Date: _____ Medicare D (Drug) Carrier: _____	Medicare HIC # (From Medicare Card)
Please indicate reason for Medicare Eligibility: ☐ Entitled Age ☐ Entitled Disability ☐ End-Stage Renal Disease ☐ Disability and Current Renal Disease		

SECTION 8 — DECLINATION OF COVERAGE

PLEASE COMPLETE IF YOU ARE DECLINING 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.

Name ☐ Employee	Reason for declining **Health**: ☐ Other Group Health Coverage – Carrier: _____ ☐ Medicare ☐ Medicaid ☐ Other Individual Health Coverage – Carrier: _____ ☐ Other (explain) _____ ☐ I am not enrolled in any health insurance plan, but do not want this coverage
Name ☐ Employee	Reason for declining **Dental**: ☐ Other Group Dental Coverage ☐ Medicaid ☐ Individual Dental Coverage ☐ Other (explain)_____ ☐ I am not enrolled in any dental insurance plan, but do not want this coverage
Name ☐ Spouse	Reason for declining: ☐ Other Group Health Coverage ☐ Medicare ☐ Medicaid ☐ Other Individual Health Coverage ☐ Other (explain)_____ ☐ I am not enrolled in any health insurance plan, but do not want this coverage
Name ☐ Dependent	Reason for declining: ☐ Other Group Health Coverage ☐ Medicare ☐ Medicaid ☐ Other Individual Health Coverage ☐ Other (explain)_____ ☐ I am not enrolled in any health insurance plan, but do not want this coverage
Name ☐ Dependent	Reason for declining: ☐ Other Group Health Coverage ☐ Medicare ☐ Medicaid ☐ Other Individual Health Coverage ☐ Other (explain)_____ ☐ I am not enrolled in any health insurance plan, but do not want this coverage

SECTION 9 — 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 Dearborn National® Life Insurance Company. 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 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). As applies to HMO coverage, I will accept an electronic copy of my coverage documents (whether certificate of coverage or benefit booklet) if my employer requests that BCBSTX deliver the information electronically. I understand that a hard copy is available to me upon request.
- 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 that written communications that are required by law may be delivered to me electronically, with my consent. I understand that if I consent to receive my documents electronically, that I have a right to obtain a paper copy and to withdraw my consent.

WARNING: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR THE PAYMENT OF A LOSS IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN STATE PRISON.

Applicant's Signature _____ Date _____