Texas Association of Counties Health and Employee Benefits Pool

Enrollment Application/Change Form

Office Personnel Use Only
Processed in OASYS:
On: _____By:_____
Worker's Comp Code:
_____

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: ☐Male ☐Female	Marital Status: ☐Single ☐Married	Employee Type: ☐Full-Time Active ☐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

☐New Enrollee Effective Date :____/____/____

☐Retirement Effective Date :____/____/____

☐Open Enrollment Effective Date :____/____/____

☐Beneficiary Change (*Complete Section 5)*

☐Name/Address Change

☐Add Dependent Event Date:____/____/____

Status Change: *Select event below to add dependent*

- ☐Birth/Adoption/Guardianship
- ☐Marriage
- ☐Court Order (QMCSO)
- ☐Add Dental for Child Under Age 5
- ☐Dependent Loses Other Coverage
- ☐Other (Explain):_____

CANCELLATION EVENTS

☐Terminate Employee (Last date worked____/____/____)

☐Cancel/Waive Employee Coverage Effective Date :____/____/____

☐Health ☐Dental ☐Basic Life and AD&D ☐Voluntary Vision

☐Cancel Dependent: ☐Health ☐Dental ☐Voluntary Vision

List dependents to be cancelled in Section 4 & Select Status Change Event Below

Status Change: Event Date:____/____/____

- ☐Death
- ☐Dependent Gains Other Coverage
- ☐Dependent Drops Coverage

(Only allowed for participants not enrolled in a cafeteria plan.)

- ☐Divorce

SECTION 3 – COVERAGE ELECTIONS - Check all that apply

Medical PPO Plan	☐Employee Only ☐Employee + 1 Child ☐Employee + Spouse ☐Employee + Children ☐Employee + Family *(Complete Section 4 to add dependents)*	☐ Waive Medical Coverage *(Complete Section 9)*
Dental PPO Plan	☐Employee Only ☐Employee + 1 Child ☐Employee + Spouse ☐Employee + Children ☐Employee + Family *(Complete Section 4 to add dependents)*	☐ Waive Dental Coverage
Life Plan VOYA Financial	☐ Employer Paid Basic Life and AD&D $_____ *(Complete Sections 5)*	☐ Waive Basic Life and AD&D
Voluntary Vision Plan Dearborn National	☐Employee Only ☐Employee + Children ☐Employee + Spouse ☐Employee + Family *(Complete Section 4 to add dependents)*	☐ Waive Vision Coverage

Group No. | Section No. | Social Security No.

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
☐ Add ☐ Drop	☐Medical ☐Dental ☐Vision	Spouse						☐ Male ☐ Female
☐ Add ☐ Drop	☐Medical ☐Dental ☐Vision	Child/Other Eligible Dep.						☐ Male ☐ Female
☐ Add ☐ Drop	☐Medical ☐Dental ☐Vision	Child/Other Eligible Dep.						☐ Male ☐ Female
☐ Add ☐ Drop	☐Medical ☐Dental ☐Vision	Child/Other Eligible Dep.						☐ Male ☐ Female
☐ Add ☐ Drop	☐Medical ☐Dental ☐Vision	Child/Other Eligible Dep.						☐ Male ☐ 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
☐ Primary ☐ Contingent					%
☐ Primary ☐ Contingent					%
☐ Primary ☐ Contingent					%
☐ Primary ☐ 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 ☐Yes ☐No	Name and Address of Other Insurance Carrier	Effective Date (MM/DD/YYYY)	Type of Policy: ☐Employee Only ☐Employee / Spouse ☐Employee / Child(ren) ☐Employee / Family
Name of Policyholder	Date of Birth (MM/DD/YYYY)	☐Male ☐Female	Relationship to Applicant: ☐Self ☐Spouse ☐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)	☐Medicare A(Hospital) Effective Date:_____ ☐Medicare B (Medical) Effective Date:_____ ☐Medicare D (Rx) Effective Date:_____ RX Carrier:_____

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_____