



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"/> Add Dental for Child Under Age 5 <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"/> Dental <input type="checkbox"/> Voluntary Vision <input type="checkbox"/> Cancel Dependent: <input type="checkbox"/> Health <input type="checkbox"/> Dental <input type="checkbox"/> Voluntary Vision <u><i>List dependents to be cancelled in Section 4 & Select Status Change Event Below</i></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		
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)	
Dental 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 Dental Coverage	
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	



Group No.

Section No.

Social Security No.

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

Table with 9 columns: Coverage Type, Relationship, Social Security No., First Name, MI, Last Name, Date of Birth, Gender. Includes checkboxes for Add/Drop and Medical/Dental/Vision.

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, Name and Address of Other Insurance Carrier, Effective Date, Type of Policy, Name of Policyholder, Date of Birth, Relationship to Applicant, Employer's Name, Employment Date, 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), Medicare A (Hospital) Effective Date, Medicare B (Medical) Effective Date, Medicare D (Rx) Effective Date, RX Carrier, Please indicate reason for Medicare Eligibility.

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 Employee, Spouse, 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.



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Group No.

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Section No.

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Social Security No.

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 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 _____

