

ENROLLMENT APPLICATION/CHANGE FORM



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<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Group No.	Section No.	Dept No.	Social Security No.
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Group No.	Section No.	Dept No.	Category

SECTION 1 — ENROLLMENT EVENTS		PLEASE CHECK ALL THAT APPLY — IF YOU ARE DECLINING COVERAGE, COMPLETE SECTIONS 2, 9, & 10 ONLY	
<input type="checkbox"/> New Enrollee <input type="checkbox"/> Add Dependent <input type="checkbox"/> Open Enrollment <input type="checkbox"/> Other Change(s) Are you applying as a result of a Special Enrollment Event? <input type="checkbox"/> No <input type="checkbox"/> Yes, Event Date: ___/___/___ Event: <input type="checkbox"/> Marriage <input type="checkbox"/> Birth <input type="checkbox"/> Adoption or Suit for Adoption (Provide Legal Documents) <input type="checkbox"/> Court Order (Provide Court Order or decree) <input type="checkbox"/> Loss of Other Coverage (Provide Certificate of Creditable Coverage) <input type="checkbox"/> Other (Explain): _____	Add Coverage: <input type="checkbox"/> Health <input type="checkbox"/> Dental <input type="checkbox"/> Term Life <input type="checkbox"/> Dependent Life <input type="checkbox"/> Short Term Disability (STD) <input type="checkbox"/> Long Term Disability (LTD)	<input type="checkbox"/> Cancel Enrollee <input type="checkbox"/> Cancel Dependent Cancel Coverage: <input type="checkbox"/> Health <input type="checkbox"/> Dental <input type="checkbox"/> Term Life <input type="checkbox"/> Dependent Life <input type="checkbox"/> STD <input type="checkbox"/> LTD List names of those cancelling in Section 4 below Event: <input type="checkbox"/> Divorce <input type="checkbox"/> Death <input type="checkbox"/> Terminated Employment <input type="checkbox"/> Other Indicate Event Date: ___/___/___	
NOTE: Declination of Coverage (Complete Sections 2, 9, & 10)			

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 No.	
Mailing Address - Street - Apt No.		City			State	Zip
E-Mail Address		<input type="checkbox"/> Male <input type="checkbox"/> Female	Home/Cell Phone No.			
Name of Employer	Job Title	Business Phone No.	Employment Date (MM/DD/YYYY)	Do you usually work at least 30 hours a week for this employer? <input type="checkbox"/> Yes <input type="checkbox"/> No		
RedRiver Systems						
Eligibility Status: <input type="checkbox"/> Active Employee <input type="checkbox"/> Retired Employee - Date of Retirement: _____ <input type="checkbox"/> COBRA Continuation		<input type="checkbox"/> State Continuation of Group Coverage (insured plans only) <input type="checkbox"/> Dependent State Continuation of Group Coverage (insured plans only)				

SECTION 3 — SELECT YOUR COVERAGE		PLEASE CHECK ALL THAT APPLY	
Small Group Plans (2-50 employees)			
Health Coverage (select one) <input type="checkbox"/> BlueChoice PPO SM <input type="checkbox"/> BlueAdvantage HMO SM 7-character Plan # (required) _____	Who is covered? (select one) <input type="checkbox"/> Employee Only <input type="checkbox"/> Employee /Spouse <input type="checkbox"/> Employee /Child(ren) <input type="checkbox"/> Family <input type="checkbox"/> I am not applying for Health coverage	BlueCare Dental Coverage <input type="checkbox"/> Yes <input type="checkbox"/> No	Who is covered? (select one) <input type="checkbox"/> Employee Only <input type="checkbox"/> Employee /Spouse <input type="checkbox"/> Employee /Child(ren) <input type="checkbox"/> Family <input type="checkbox"/> I am not applying for Dental coverage
Large Group Plans (more than 50 Employees)			
Health Coverage (select one) <input type="checkbox"/> BlueChoice PPO SM <input type="checkbox"/> EPO <input type="checkbox"/> BlueEdge HCA SM <input type="checkbox"/> HMOBlue SM Texas <input type="checkbox"/> BlueEdge HSA SM <input type="checkbox"/> BlueAdvantage HMO <input type="checkbox"/> BlueOptions SM <input type="checkbox"/> Community HMO <input type="checkbox"/> Other _____ Plan # _____	Who is covered? (select one) <input type="checkbox"/> Employee Only <input type="checkbox"/> Employee /Spouse <input type="checkbox"/> Employee /Child(ren) <input type="checkbox"/> Family <input type="checkbox"/> I am not applying for Health coverage	Dental Coverage <input type="checkbox"/> Yes <input type="checkbox"/> No Plan # (required) _____	Who is covered? (select one) <input type="checkbox"/> Employee Only <input type="checkbox"/> Employee /Spouse <input type="checkbox"/> Employee /Child(ren) <input type="checkbox"/> Family <input type="checkbox"/> I am not applying for Dental 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: _____

SECTION 4 — COVERAGE OPTIONS		SELECT A PCP FOR HMO OR POS ONLY			
Employee/Enrollee's Name	PCP Name	PCP No.	New Patient? <input type="checkbox"/> Y <input type="checkbox"/> N		
Dependent's Name <input type="checkbox"/> Husband <input type="checkbox"/> Wife	Dependent's PCP Name	PCP No.	New Patient? <input type="checkbox"/> Y <input type="checkbox"/> N		
Dependent's Social Security No.	Birth Date (MM/DD/YYYY)	Address (if different) - No. and Street Address		City	State Zip
Dependent's Name <input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Other Eligible Dependent _____	Dependent's Social Security No.	Dependent's PCP Name	PCP No.	New Patient? <input type="checkbox"/> Y <input type="checkbox"/> N	
Birth Date (MM/DD/YYYY)	Home Address, if different — No. and Street Name/City/State/Zip	Is this dependent a natural child, stepchild, eligible foster child, adopted child, or a child in Suit for Adoption? <input type="checkbox"/> Y <input type="checkbox"/> N	If not your natural child, stepchild, eligible foster child, adopted child or child in Suit for Adoption, are you (or your spouse) responsible for this dependent? <input type="checkbox"/> Y <input type="checkbox"/> N		
Dependent's Name <input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Other Eligible Dependent _____	Dependent's Social Security No.	Dependent's PCP Name	PCP No.	New Patient? <input type="checkbox"/> Y <input type="checkbox"/> N	
Birth Date (MM/DD/YYYY)	Home Address, if different — No. and Street Name/City/State/Zip	Is this dependent a natural child, stepchild, eligible foster child, adopted child, or a child in Suit for Adoption? <input type="checkbox"/> Y <input type="checkbox"/> N	If not your natural child, stepchild, eligible foster child, adopted child or child in Suit for Adoption, are you (or your spouse) responsible for this dependent? <input type="checkbox"/> Y <input type="checkbox"/> N		
Dependent's Name <input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Other Eligible Dependent _____	Dependent's Social Security No.	Dependent's PCP Name	PCP No.	New Patient? <input type="checkbox"/> Y <input type="checkbox"/> N	
Birth Date (MM/DD/YYYY)	Home Address, if different — No. and Street Name/City/State/Zip	Is this dependent a natural child, stepchild, eligible foster child, adopted child, or a child in Suit for Adoption? <input type="checkbox"/> Y <input type="checkbox"/> N	If not your natural child, stepchild, eligible foster child, adopted child or child in Suit for Adoption, are you (or your spouse) responsible for this dependent? <input type="checkbox"/> Y <input type="checkbox"/> N		

Last Name:

Social Security No.:

Group #

SECTION 5 — GROUP TERM LIFE, ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D), AND DISABILITY INSURANCE COVERAGES

Employee Occupation/Job Title: _____ Wage Rate \$ _____ per hour week month year
Group Basic Term Life & 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 (STD) I do not apply I do apply
Long Term Disability (LTD) I do not apply I do apply
Primary Beneficiary First Name Initial Last Name Relationship Birth Date (MM/DD/YYYY) Social Security No.
Contingent Beneficiary First Name Initial Last Name Relationship Birth Date (MM/DD/YYYY) Social Security No.

SECTION 6 — DISABLED DEPENDENT

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 7 — OTHER COVERAGE INFORMATION

Complete this section only if you or any of your dependents have other health and / or dental coverage that will not be cancelled when the coverage under this application becomes effective. List names of each individual covered:
Group Coverage Yes No Name and Address of Other Insurance Carrier Effective Date (MM/DD/YYYY) Type of Policy
Name of Policyholder Birth Date (MM/DD/YYYY) Relationship to Applicant
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

Name of person covered: Medicare A (Hospital) Effective Date: _____ End Date: _____ Medicare HIC No. (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 HIC No. (From Medicare Card)
Please indicate reason for Medicare Eligibility: Entitled Age Entitled Disability End-Stage Renal Disease Disability and Current Renal Disease

SECTION 9 — DECLINATION OF 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
Name Employee Reason for Declining Dental: Other Group Dental Coverage Medicaid Individual Dental Coverage
Name Spouse Reason for declining: Other Group Health Coverage Medicare Medicaid Other Individual Health Coverage
Name Child Reason for declining: Other Group Health Coverage Medicare Medicaid Other Individual Health Coverage
Name Child Reason for declining: Other Group Health Coverage Medicare Medicaid Other Individual Health Coverage

SECTION 10 — 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 Contracts(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 receiving my documents electronically, that I have a right to obtain a paper copy and to withdraw my consent.
Applicant's Signature _____ Date _____

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