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: Refugio County Group Number: 120157

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: _____
☐Name/Address Change
☐Beneficiary Change (Complete Section 5)
☐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: _____
☐Medical ☐Dental ☐Vision

☐Cancel Dependent: ☐Medical ☐Dental ☐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
☐Divorce

*Dependents may drop coverage if the employee is not enrolled in a cafeteria plan.

SECTION 3 – COVERAGE ELECTIONS – Select plan and coverage tiers.

Medical & Rx Plan	☐Employee Only ☐Employee + Children ☐Employee + Spouse ☐Employee + Family (Complete Section 4 to add dependents)	☐Waive Medical Coverage (Complete Section 9)
Dental Plan	☐Employee Only ☐Employee + Children ☐Employee + Spouse ☐Employee + Family (Complete Section 4 to add dependents)	☐Waive Dental Coverage
Life Plan	☑Employer Paid Basic Life and AD&D $ 10,000	
Vision Plan	☐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 complete dependents to add coverage.

☐Add ☐Drop	☐Medical ☐Dental ☐Vision	Spouse	SSN	First Name	MI	Last Name	Date of Birth	Gender ☐Male ☐Female
☐Add ☐Drop	☐Medical ☐Dental ☐Vision	Child/Other Eligible Dep.	SSN	First Name	MI	Last Name	Date of Birth	Gender ☐Male ☐Female
☐Add ☐Drop	☐Medical ☐Dental ☐Vision	Child/Other Eligible Dep.	SSN	First Name	MI	Lasti Name	Date of Birth	Gender ☐Male ☐Female
☐Add ☐Drop	☐Medical ☐Dental ☐Vision	Child/Other Eligible Dep.	SSN	First Name	MI	Lasti Name	Date of Birth	Gender ☐Male ☐Female
☐Add ☐Drop	☐Medical ☐Dental ☐Vision	Child/Other Eligible Dep.	SSN	First Name	MI	Lasti Name	Date of Birth	Gender ☐Male ☐Female

SECTION 5 – BENEFICIARY INFORMATION – Designate your beneficiary below. (REQUIRED)

BENEFICIARY DESIGNATION: Employees must choose beneficiaries for Life and AD&D insurance. If two or more primary beneficiaries are listed, 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.

Select	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	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 A(Hospital) Effective Date: _____	Please indicate reason for Medicare Eligibility: ☐Entitled Age
Medicare HIC No. (from Medicare Card)	☐Medicare B (Medical) Effective Date: _____ ☐Medicare D (Rx) Effective Date: _____ RX Carrier: _____	☐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 my employer has explained to me the available coverage. I have been given the opportunity to apply for the coverage offered to me and my eligible dependent(s) and have voluntarily chosen to decline the coverage as indicated below. If I want to apply for coverage later, I understand there may be a delay in the effective date of the coverage.

Employee Name	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 _____
Spouse Name	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 _____
Child(ren) Name	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 affirm that I am an employee of the Employer named in this Enrollment Application and that I meet the requirements to participate in the coverage(s) provided by my Employer's plan. I confirm that all the information provided in this Enrollment Application is accurate and truthful. I acknowledge that any deliberate misrepresentation of a significant fact on my part will result in the invalidation of my coverage(s).
- On behalf of myself and any dependents listed in this Enrollment Application, I hereby request the eligible coverage(s). I acknowledge that only the coverage(s) and amounts for which I am eligible will be available to me. If my Enrollment Application is accepted, the coverage(s) will become effective based on the provisions of the Contract(s)/Plan(s).
- I understand that voluntary life coverage may require evidence of insurability for it to become effective.
- I understand that my coverage will begin on the effective date assigned by my employer, provided that I am actively at work.
- I understand that my participation in the coverage(s) is subject to any future amendments. I acknowledge that any notices given to my Employer also apply to me.
- The plan is underwritten or administered by Texas Association of Counties Health and Employee Benefits Pool (TACHEBP) / Blue Cross and Blue Shield of Texas (BCBSTX) or Dearborn Life Insurance Company. Dearborn Life Insurance Company operates under the trade name Blue Cross and Blue Shield of Texas and is an authorized licensee of the Blue Cross and Blue Shield Association.

Applicant's Signature_____Date_____