Ancilliary Products

Enrollment/ Change Request / Waiver

BlueCross BlueShield of TX

Effective date: ___ /___ / _____ BCBS□ UP□

☐ **I decline all coverages for myself and my family**

☐ **Voluntary short term disability**

☐ **Supplemental Life declined**

A. Type of Activity

Enrollment - *Check One*		**Change** - *Check all that apply*	**Remove or terminate** *Check all that apply*
□**OPEN Enrollment**	□**EOI Completed**	□ Name Change /Address	□ Remove Spouse
□ **New Enrollee**	□**Rehire /re-enroll**	□ Add Spouse	□ Remove Dep. Child
Date of Hire	Date of Rehire	□ Add Dependent Child	□ Cancel Coverage
__ / ___ / ____	__ / ___ / ____	□ Other _____	

□Special Enrollment □Loss of coverage

□ Adoption □ Marriage □Divorce □Birth

Loss of coverage of Previous insurance info attached

Date of Loss of Coverage: ___ / ____ / _____

B. Employee Information

Social Security Number	Last name, First Name, Middle Initial EE ID#	Telephone Number	□Male □Female
Date of Birth	Home Address	Apt. # / City, State	Zip

C. Plan Options - LIFE & Disability Products

□ Basic Life Employee Only	$5,000 Employer Sponsored
□ Employee Supplemental Life	Annual Salary _____ □1 time □2 time □ 3 time
□ Employee Voluntary Short Term disability (Variable premium by age) AGE_____	

D. Dependent Plan Options

□ Spouse Supp life	$5,000 Increments up to $50,000 MAX can not be more than EE coverage
□ Child Supp life	$2,500 Increments up to $10,000 MAX

E. Dependents Covered

Name (First, MI, Last)	[A]dd [R]emove	Relation	Sex M/F	Birthdate	SSN	Supp Life	Coverage Amount	EOI
		Spouse		/ /		□		
		Child		/ /		□		
		Child		/ /		□		
		Child		/ /		□		

Life Insurance Beneficiary:	Name	Relationship:	SS# or DOB	%
#1				
#2				
#3				

F. Declination of Coverage

This is to certify the available coverage has been explained to me. I have been given the opportunity to apply for all the coverages offered to me and my eligible dependents and have voluntarily elected to decline the coverage. If I apply at a later date I understand there may be a delay in the effective date of my coverage. My signature acknowledge declining coverage X_____

Employee Signature

THIS FORM MUST BE SIGNED AND RETURNED TO HUMAN RESOURCES

I certify that all information supplied in this form is true and complete to the best of my knowledge and/or belief. I have read and agree to the Conditions of Enrollment provided to me by my benefits coordinator.

Employee Signature

X Date:

Email Address: