Medical /Dental / Vision Enrollment / Change Request / Waiver

Jul-21 BlueCross BlueShield of TX

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

□ **Medical Coverage Declined**
Must complete "section F" below
□**Dental Coverage Declined**
□**Vision Coverage Declined**

A. Type of Activity

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

□Special Enrollment □Loss of coverage
□ Adoption □ Married □Divorce □Birth
Loss of coverage 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

Check all that apply

□ Medical PPO (F/T ONLY)
□ BCBS FTE (P/T ONLY)
□ Dental BCBS
□ Vision BCBS

D. Monthly Premiums

Employee and Dependent monthly premiums are divided into 2 paychecks

Employee Only		Employee + **Spouse**		Employee **+ Child**		Employee + **Family**	
Medical	~~$604.30~~	□ Medical	$954.88	□ Medical	$622.52	□ Medical	$1,577.33
FTE MED	$87.00						
Dental	$27.93	□ Dental	$54.84	□ Dental	$68.11	□ Dental	$95.03
Vision	7.31	□ Vision	13.29	□ Vision	14.03	□ Vision	21.52

E. Dependents Covered

Name (First, MI, Last)	[A]dd [R]emove	Relation	Sex M/F	Birthdate	SSN	*Check all that apply* Medical	Dental	Vision
		Spouse		/ /		□	□	□
		Child		/ /		□	□	□
		Child		/ /		□	□	□
		Child		/ /		□	□	□
		Child		/ /		□	□	□

*If "Yes" to other Medical Coverage Above, provide copy of your Member ID card.

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 the coverage 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. **Reason for Declining**: □ Other Group Health Coverage □ Medicare □ Medicaid □ Other Individual coverage □ I am not enrolled but do not want coverage

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: