Blue Cross Blue Shield of TX July 2020 Medical/Dental Enrollment/Change Request / Waiver

Effective date: __________ ID #

☐ **Coverage Declined**
Must complete section E below

A. Type of Activity

Enrollment - *Check One*		Change - *Check all that apply*	Remove or terminate *Check all that apply*	
☐ New Enrollee/Subscriber	☐Rehire	☐ Add Spouse	☐ Remove Spouse	☐OPEN Enrollment
Date of Hire	Date of Rehire	☐ Add Dependent Child	☐ Remove Dep. Child	☐Special Enrollment ☐Loss of coverage ☐Divorce
__ / ___ / ____	__ / ___ / ____	☐ Name Change /Address	☐ Cancel Coverage	☐ Adoption ☐ Married
		☐ Other ____________		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 / D. Monthly Premiums

C. Plan Options	Employee Only		Employee + Spouse		Employee + Child		Employee + Family	
☐ BCBS PPO (Medical)	Medical	$592.45 PAID BY MG	Medical	$936.16	Medical	$610.32	Medical	$1,546.41
☐ BCBS FTE (P/T ONLY)	FTE MED	$87.00	N/A		N/A		N/A	
☐ BCBS Dental	Dental	$27.93	Dental	$54.84	Dental	$68.11	Dental	$95.03

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

E. Dependents

Name (First, MI, Last)	[A]dd [C]hange [R]emove	Relation Hus/Wife Son/Daughter	Sex M/F	Birthdate	SSN	Medical	Dental	Other Med. Coverage*
				/ /		☐	☐	☐
				/ /		☐	☐	☐
				/ /		☐	☐	☐
				/ /		☐	☐	☐

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

E. 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 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: