



Last Name:

Social Security Number:

H Group #

SECTION 6 — PREVIOUS COVERAGE INFORMATION

In order to receive credit for pre-existing condition waiting periods, you must provide information about the last 12 months of coverage (18 months if new/current coverage is self-funded) for you and any dependents listed. If you have a certificate of prior coverage, please attach a copy to this enrollment application. (If more than one plan was in effect, or if information is different for dependents, attach additional pages.) If Medicare, please complete the Medicare Coverage Information in Section 8. List names of every individual covered:

Table with columns: Name of Primary Enrollee, Birth Date (Mo Day Yr), Male/Female, Relationship to Applicant, Employment Date, Will Coverage be Continued?, Type of Coverage, Group or Policy No., ID Number.

SECTION 7 — OTHER COVERAGE INFORMATION

Are you or any member of your family listed above covered by any other health or dental coverage? Yes No List names of every individual covered:

Table with columns: Type of Coverage (Health/Dental), Group Coverage (Yes/No), Name and Address of Other Health Care Company, Birth Date (Mo Day Yr), Male/Female, Relationship to Applicant, Employment Date, Effective Date of Coverage, Group or Policy Number, Type of Coverage (Self/Two Person/Family).

SECTION 8 — MEDICARE COVERAGE INFORMATION

Table with columns: Name of person covered, Medicare A (Hospital) Effective Date, Medicare B (Medical) Effective Date, Medicare A (Hospital) Effective Date, Medicare B (Medical) Effective Date, Medicare No. (From Medicare Card).

SECTION 9 — DISABLED DEPENDENT

Name of disabled dependent

Nature of disability

Has disability been diagnosed as permanent? Yes No If temporary, how long is dependent expected to remain disabled? Is dependent unable to work due to the disability? Yes No

SECTION 10 — DECLINATION OF HEALTH 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 as well as a pre-existing condition waiting period.

Table with columns: Name (Employee, Spouse, Child), Reason for declining (Other Group Coverage, Medicare, Medicaid, Other), Medicare/Medicaid/Other explain.

SECTION 11 — 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 (BOBSTX), HMO Blue Texas, or Fort Dearborn Life Insurance Company (FDL). 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 incorrect statements material to the risk and knowingly 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 Contract(s).
I understand that the health coverage I am applying for may be subject to a pre-existing condition exclusion (not applicable if applying for HMO or In-Hospital Indemnity).
I authorize necessary payroll deduction by my Employer, if any, to cover the cost of my coverage(s). I agree that my Employer acts as my agent. All notices given to my Employer are binding upon me. I also agree that my participation in the coverage(s) is subject to any future amendments.

Applicant's Signature, Date, Employer Verification Signature (Optional), Date