H

Group #	Section #	Dept #	Social Security Number
Group #	Section #	Dept #	Category

ENROLLMENT APPLICATION/CHANGE FORM

BlueCross BlueShield of Texas

Fort Dearborn Life Insurance Company

SECTION 1 — ENROLLMENT EVENTS

PLEASE CHECK ALL THAT APPLY

☐ **New Enrollee** ☐ **Add Dependent**
Event: ☐ Marriage ☐ Birth or Adoption
☐ Court Order (See Instructions)
☐ Suit for Adoption
☐ Other (See Instructions) Explain:

Indicate Event Date: ____ / ____ / ____
Add Coverage: ☐ Health ☐ Dental
☐ Term Life ☐ Dependent Life
☐ Short Term Disability (STD)
☐ Long Term Disability (LTD)
☐ Change Primary Care Physician (PCP) or Primary Care Dentist (PCD). Reason:

☐ **Cancel Enrollee** ☐ **Cancel Dependent**
List names of those canceling in section 4 below
Event: ☐ Divorce ☐ Death
☐ Terminated Employment
Indicate Event Date: ____ / ____ / ____
Cancel Coverage: ☐ Health ☐ Dental
☐ Term Life ☐ Dependent Life
☐ STD ☐ LTD
☐ Change Address/Name
☐ Declination of Coverage (refer to section 10)

Are you applying as a result of a Special Enrollment Event? ☐ **Yes** ☐ **No** **If yes, indicate Event Date:**
☐ Married ☐ Birth or Adoption
☐ Suit for Adoption ☐ Court Order
☐ Loss of Coverage (provide Certification of Coverage)
☐ Other. Explain:

Indicate Event Date: ____ / ____ / ____

SECTION 2 — PLEASE TELL US ABOUT YOURSELF

Last Name	First	Middle	Birth Date (Mo Day Yr)	Social Security Number

Sex ☐ Male ☐ Female	Employment Date (Mo Day Yr)	Name of Employer	Payroll No.	Work Phone No. ( )

Home Address — No. and Street Address	City	State	Zip	Do you usually work at least 30 hours a week for this employer? ☐ Y ☐ N	Home Phone No. ( )

SECTION 3 — SELECT YOUR COVERAGE

Health (select one)

____ PLAN A
____ PLAN B
____ PLAN C

Enrollees (select one)
☐ Employee Only
☐ Employee/Spouse
☐ Employee/Child(ren)
☐ Family
☐ I DO NOT APPLY

PPO Network (select one)
☒ BlueChoice® Network
☐ BlueChoice Solutions[SM] Network

Complete only if you are applying for HMO coverage. Primary Language: ☐ Check here to request a Spanish Member Handbook
Do you have a disability affecting your ability to communicate or read? ☐ Yes ☐ No Describe special communication materials needed:

SECTION 4 — COVERAGE OPTIONS

SELECT A PCP FOR HMO OR POS ONLY. SELECT A PCD FOR HMO BLUE TEXAS DENTAL RIDER ONLY. **OB/GYN No.**

Employee/Enrollee's Name

Dependent's Name ☐ Husband ☐ Wife

Dependent's Social Security No.	DOB (Mo Day Yr)	Home Address, if different — No. and Street Name	City	State	Zip

Dependent's Name ☐ Son ☐ Daughter

Dependent's Social Security No.	DOB (Mo Day Yr)	Home Address, if different — No. and Street Name	City	State	Zip

Dependent's Name ☐ Son ☐ Daughter

Dependent's Social Security No.	DOB (Mo Day Yr)	Home Address, if different — No. and Street Name	City	State	Zip

Dependent's Name ☐ Son ☐ Daughter

Dependent's Social Security No.	DOB (Mo Day Yr)	Home Address, if different — No. and Street Name	City	State	Zip

SECTION 5 — GROUP TERM LIFE INSURANCE, ACCIDENT AND DISABILITY COVERAGES

Employee Occupation: ☐ Salary ☐ Hourly Wage Rate $______ per ☐ Hour ☐ Week ☐ Month ☐ Year

Group Basic Life & AD&D ☐ I Apply ☐ I Do Not Apply Amount $______ Group Supplemental Life ☐ I Apply ☐ I Do Not Apply Amount $______

Group Dependent Life ☐ I Apply ☐ I Do Not Apply Spouse Volume $______ 6 mos. to older $______ Dep Child Volume – 15 days to 6 mos. $______ Students $______

Short Term Disability (STD) ☐ I Apply ☐ I Do Not Apply Long Term Disability (LTD) ☐ I Apply ☐ I Do Not Apply

	First Name	Initial	Last Name	Relationship	Date of Birth	Social Security No.
Primary Beneficiary					/ /	
Contingent Beneficiary					/ /	

H

Group # | Section # | Dept # | Social Security Number

Group # | Section # | Dept # | Category

ENROLLMENT APPLICATION/CHANGE FORM

BlueCross BlueShield of Texas

Fort Dearborn Life Insurance Company

SECTION 1 — ENROLLMENT EVENTS

PLEASE CHECK ALL THAT APPLY

☐ **New Enrollee** ☐ **Add Dependent**
Event: ☐ Marriage ☐ Birth or Adoption
☐ Court Order (See Instructions)
☐ Suit for Adoption
☐ Other (See Instructions) Explain:

Indicate Event Date: ____/____/____
Add Coverage: ☐ Health ☐ Dental ☐ Term Life ☐ Dependent Life ☐ Short Term Disability (STD) ☐ Long Term Disability (LTD)

☐ Change Primary Care Physician (PCP) or Primary Care Dentist (PCD). Reason:

☐ **Cancel Enrollee** ☐ **Cancel Dependent**
List names of those canceling in section 4 below
Event: ☐ Divorce ☐ Death ☐ Terminated Employment
Indicate Event Date: ____/____/____
Cancel Coverage: ☐ Health ☐ Dental ☐ Term Life ☐ Dependent Life ☐ STD ☐ LTD

☐ Change Address/Name
☐ Declination of Coverage (refer to section 10)

Are you applying as a result of a Special Enrollment Event? ☐ **Yes** ☐ **No** **If yes, Indicate Event Date:**

☐ Married ☐ Birth or Adoption
☐ Suit for Adoption ☐ Court Order
☐ Loss of Coverage (provide Certification of Coverage)
☐ Other. Explain:

Indicate Event Date: ____/____/____

SECTION 2 — PLEASE TELL US ABOUT YOURSELF

Last Name	First	Middle	Birth Date (Mo Day Yr)	Social Security Number

Sex	Employment Date (Mo Day Yr)	Name of Employer	Payroll No.	Work Phone No.
☐ Male ☐ Female				( )

Home Address — No. and Street Address	City	State	Zip	Do you usually work at least 30 hours a week for this employer? ☐ Y ☐ N	Home Phone No.
					( )

SECTION 3 — SELECT YOUR COVERAGE

Health (select one)

___ PLAN A
___ PLAN B
___ PLAN C

Enrollees (select one)
☐ Employee Only
☐ Employee/Spouse
☐ Employee/Child(ren)
☐ Family
☐ I DO NOT APPLY

PPO Network (select one)
☒ BlueChoice℠ Network
☐ BlueChoice Solutions℠ Network

Complete only if you are applying for HMO coverage. Primary Language: ☐ Check here to request a Spanish Member Handbook

Do you have a disability affecting your ability to communicate or read? ☐ Yes ☐ No Describe special communication materials needed:

SECTION 4 — COVERAGE OPTIONS

SELECT A PCP FOR HMO OR POS ONLY. SELECT A PCD FOR HMO BLUE TEXAS DENTAL RIDER ONLY. **OB/GYN No.**

Employee/Enrollee's Name

Dependent's Name ☐ Husband ☐ Wife

Dependent's Social Security No.	DOB (Mo Day Yr)	Home Address, if different — No. and Street Name	City	State	Zip

Dependent's Name ☐ Son ☐ Daughter

Dependent's Social Security No.	DOB (Mo Day Yr)	Home Address, if different — No. and Street Name	City	State	Zip

Dependent's Name ☐ Son ☐ Daughter

Dependent's Social Security No.	DOB (Mo Day Yr)	Home Address, if different — No. and Street Name	City	State	Zip

Dependent's Name ☐ Son ☐ Daughter

Dependent's Social Security No.	DOB (Mo Day Yr)	Home Address, if different — No. and Street Name	City	State	Zip

SECTION 5 — GROUP TERM LIFE INSURANCE, ACCIDENT AND DISABILITY COVERAGES

Employee Occupation: ☐ Salary ☐ Hourly Wage Rate $______ per ☐ Hour ☐ Week ☐ Month ☐ Year

Group Basic Life & AD&D ☐ I Apply ☐ I Do Not Apply Amount $______ Group Supplemental Life ☐ I Apply ☐ I Do Not Apply Amount $______

Group Dependent Life ☐ I Apply ☐ I Do Not Apply Spouse Volume $______ 6 mos. to older $______ Dep Child Volume – 15 days to 6 mos. $______ Students $______

Short Term Disability (STD) ☐ I Apply ☐ I Do Not Apply Long Term Disability (LTD) ☐ I Apply ☐ I Do Not Apply

	First Name	Initial	Last Name	Relationship	Date of Birth	Social Security No.
Primary Beneficiary					/ /	
Contingent Beneficiary					/ /	

METROPOLITAN LIFE INSURANCE COMPANY
ENROLLMENT FOR GROUP DENTAL COVERAGE

MetLife®

TO BE COMPLETED BY EMPLOYER

Group Name: _____

Group Number: _____ Subdivision: _____ Branch: _____

Effective Date of Coverage	Month	Day	Year	Cancellation Date of Coverage	Month	Day	Year

TO BE COMPLETED BY EMPLOYEE

Please print clearly and be sure to sign and date this form. Return your completed form to your employer's office.

Your Name: _____
(Last) (First) (Middle Initial)

Your Address: _____
(Street) (City) (State) (Zip Code)

Social Security Number: _____ **Date of Birth:** (Mo./Day/Yr.) _____

Work Status: ☐ Active ☐ Retired **Date of Employment:** (Mo./Day/Yr.) _____

☐ Original COBRA Effective Date: (Mo./Day/Yr.) _____

Sex: ☐ Male ☐ Female **Marital Status:** ☐ Single ☐ Married ☐ Divorced ☐ Widowed

I received and read a copy of my employer's current announcement of the group plan.

☐ **I want to be covered** under the group plan for which I am or may become eligible.
☐ I want personal coverage only. ☐ I want personal and dependent coverage.

My Dependent Coverage is for: ☐ Spouse ☐ Spouse and Child(ren) ☐ Child(ren) Only

Spouse's Name: _____ **Date of Birth:** (Mo./Day/Yr.) _____

Name of Child(ren): _____ **Date of Birth:** _____

_____ **Date of Birth:** _____

_____ **Date of Birth:** _____

_____ **Date of Birth:** _____

- **I authorize** my employer to deduct from my pay any required contributions to the cost of this coverage.

☐ **I do not want to be covered** for the group dental benefits for which I am eligible.

I declare that the information given above is true and complete to the best of my knowledge and belief, and that I am actively at work on the date of this enrollment.

▶**Signed (Employee)** _____ **Date** _____