88/CHG3 1003

Group # Section # Group # Section #	Dept # Social	Security Number Category	Blu of	jeCross Bluc\$ Texas	hield	()	FORT DEARMORN LIFE INSURANCE COMPANY
ECTION 1 - ENROLLMENT	EVENTS	SECTATION AND CONTROL	AUDITHAT APPLY DE				
New Enrollee [] Add Depende		el Enrollee 🗆 Canco					a Special Enrollmen icate Event Date;
vent: ☐ Marriage ☐ Birth or Adopt ☐ Court Order (See Instruction	(e)	es of those canceling in s	section 4 below	☐ Mar		-	irth or Adoption
☐ Suit for Adoption ☐ Other (See Instructions) Exp	Event	☐ Divorce ☐ Death ☐ Terminated Employ	ment		for Adoption		ourt Order
	Indiant	e Event Date:/	/	[•		rtification of Coverage)
ndicate Event Date://_dd □ Dental	Cancel				r. Explain:		and the same of th
overage: 🗀 Term Life 🗆 Dependent I Short Term Disability (STE		ge: □ Term Life □ Do □ STD □ LTD	ependent Lite		I. Explain	".	
□ Long Term Disability (LTD)	e Address/Name					,
Change Primary Care Physician (PCP) of Care Dentist (PCD), Reason:	Declin	nation of Coverage (refer	to section 10)	Indicate	Event Date:	— / <u> </u>	
ECTION 2 — PLEASE TELL		JRSELF	Diet De	A /Ma 12au Mai		voial Carn	rity Number
st Name	Pirst	Middle	Birth Da	te (Mo Day Yr)	50	ciai secui	rity Number
Sex Employment Date	(Mo Day Yr) Name of	Employer			Payroll No.		ione No.
Male - Female)
ome Address — No. and Street Address	City	State	Zip Do	you usualiy work veek for this empl	at least 30 hours loyer? □ Y □ N	Home Pi	hone No.)
ECTION 3 — SELECT YOUR	COVERAGE			iota iot nas		`	,
alth (select one)		Enrollees (select one)	PPO Network (se				
,	<u>,</u>	☐ Employee Only	BlueChotce* !				
PLAN Z		⊞ Employee/Spouse ⊞ Employee/Child(ren)	BlucChoice Se	olutions ^M			
PLAN		☐ Family					
		LJ 1 DO NOT APPLY					4- hannes (AAV ARAF VAA
you have a disability affecting your abili ECTION 4 — COVERAGE OF	ty to communicate or	rimary Lunguage: read? □ Yes □ No Desc LECTAPEP FOR HMO OR !	ribe special commu POS ONLY SPLECT A	inication mater	dats needed:		
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EE/CHG3 1003

Group #	Section #	Dept #	Category BlueCross BlueShield of Texas					V.	FORT DEARBORN LIFE INSURANCE COMPANY
ECTION 1	ENROLLMENT	EVENT	5 .	3 27 - TV 20 - TV 30	ALC THAT APPLY				
New Enrolles	☐ Add Depend	lent	🗆 Çance	l Enrollee 🔠 Cance	el Dependent	Arc you	applying as a r 🗆 Yes 🗆 No If	vesult of a ? yes, Indica	Special Enrollment ate Event Date:
	e - 🗀 Birth or Adop rder (See Instructio			es of those canceling in	section 4 below		farried		or Adoption
Suit for	Adoption		Event:	☐ Divorce ☐ Death ☐ Terminated Employ	ment		uit for Adoption	☐ Cour	-
	See Instructions) Ex		Indicate	e Event Date:/			•		fication of Coverage)
dicate Event Dat Id 🔲 Health	te:/ h □ Dental		Cancel	🗆 Health 🔲 Dent	al	1		manac cerm	(10,11111111111111111111111111111111111
verage: 🗀 Term	life 🔲 Dependent	t Life	Coverag	ze: 🗆 Term Life 🗀 Do	ependent Life		other, Explain:		
□ Long	Term Disability (ST Term Disability (LTI	ר)		□ STO □ LTD e Address/Name					
Change Primary Car	re Physician (PCP) (or Primary	☐ Declin	ation of Coverage (refer	to section 10)	Indica	te Event Date:	/	···- /
Care Dentist (PCD).	PLEASE TELL	US ABO		RSELF					
st Name		First		Middle	Birth	Date (Mo Day	Yr) So	cial Security	Number
							<u>ii</u>	Work Phor	No. No.
Sex	Employment Date	: (Mo Day Y	r) Name of	Employer		•	Payroll No.	()	ic No.
Male ∏ Female	and Street Address		City	State	Zip	Do you usually v	ork at least 30 hours	Home Pho	ne No.
ime address No). and bifeet Address	n	· · · · ·	24		a week for this	employer? 🎞 Y 🗀 N	()	
ECTION 3	SELECT YOU	R COVER	AGE						
tith (select one)			P	Inrollees (select one)	PPO Network		1		
	PLAN	Δ	Ľ	Employee Only	BlueChoid	ce™ Network ce Solutions™	•		
-			L	Employee/SpouseEmployee/Child(ren)		LE Miunons			
	PLAN	C		Family I DO NOT APPLY					
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you have a disabili ECITON 4 — mployec/Enrolle ependent's Name	iy affecting your abi COVERAGE O e's Name e 🖂 Husband 🗆 Wi	ility to comm	nunicate or r	read? 🗀 Yes 🗀 No Desc	POS ONLY. SELE	nmunication m	aterials needed:		
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METROPOLITAN LIFE INSURANCE COMPANY ENROLLMENT FOR GROUP DENTAL COVERAGE

MetLife[®]

TO BE COMPLETED BY EMPLOYER

roup Name:									
roup Number:	Subdivision:				Branch:				
Effective Date of Coverage	Month	Day	Year	Cancellation	Date of Coverage	Month	Day	Year	
				ED BY EM			45.00	<u> </u>	
ease print clearly and be sure to sign				rn your compi	etea form to your er	nployer s o	nce.		
ur Name:(L.	Name:(Last)			(First)	****	(Middle Initial)			
our Address:(S	veet)			(City)	(Mo./Da	(State)		(Zip Code)	
ocial Security Number:				ate of Birth:					
ork Status: Active Retired	Date	of Emp	lovmen	t:	(Mo./Day/Yr.				
ex:	er the group coverage o	plan fo	announc or which □ Spouse	ement of the g I am or may b I want person and Child(ren)	ecome eligible. al and dependent co	overage. y (Mo./Da	y/Yr.)		
ame of Child(ren):					Date of Birth:	!			
					Date of Birth:				
					Date of Birth:				
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					ay any required co				
I do not want to be cove	red for the	group o	lental be	nefits for which	h I am eligible.				
declare that the information given actively at work on the date of	ren above f this enro	is true Ilment	and co	mplete to the	e best of my knov	vledge and	l belief,	and that	
►Signed (Employee)						O:	ite		
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