



Last Name:

Social Security Number:

H Group #

SECTION 6 — PREVIOUS COVERAGE INFORMATION COMPLETE ONLY IF APPLYING FOR COVERAGE OTHER THAN HMO OR IN-HOSPITAL INDEMNITY

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:

Form with fields for Name of Primary Enrollee, Birth Date, Gender, Relationship to Applicant, Group or Policy No., ID Number, Employer's Name, Employment Date, Effective Date, Will Coverage be Continued?, If No, Expected Cancel Date, Type of Coverage, and Type of Policy.

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:

Form with fields for Type of Coverage, Group Coverage, Name and Address of Other Health Care Company, Name of Policyholder, Birth Date, Gender, Relationship to Applicant, Type of Coverage, ID Number, Employment Date, Effective Date of Coverage, Group or Policy Number, and Employer's Name.

SECTION 8 — MEDICARE COVERAGE INFORMATION

Form with fields for Name of person covered, Medicare A (Hospital) Effective Date, Medicare B (Medical) Effective Date, and Medicare No. (From Medicare Card).

Please check the reason for Medicare Eligibility Entitled Age Entitled Disability End-Stage Renal Disease Disability and Current Renal Disease

SECTION 9 — DISABLED DEPENDENT

Form with fields for Name of disabled dependent, Nature of disability, Has disability been diagnosed as permanent?, and Is dependent unable to work due to the disability?.

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 5 rows for Name, Reason for declining, and checkboxes for Other Group Coverage, Medicare, Medicaid, and 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 (BCBSTX), 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

A Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association

Fort Dearborn Life Insurance Company, a Member of the Preferred Financial Group