

BLUE CROSS BLUE SHIELD ENROLLMENT FORM

ANGELS OF CARE

Name:	Date of Birth:
Address:	Date of Hire:
	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
Social Security #:	Email:
Home Phone #:	Business Phone #:

SELECT COVERAGE:

MEDICAL OPTION #1: <input type="checkbox"/> PPO RM-26		<input type="checkbox"/> Decline Medical	
Select Enrollees: (per paycheck cost)			
<input type="checkbox"/> Employee Only (\$112.03)	<input type="checkbox"/> Employee/Children (\$321.65)		
<input type="checkbox"/> Employee/ Spouse (\$452.65)	<input type="checkbox"/> Employee/Family (\$662.28)		

MEDICAL OPTION #2: <input type="checkbox"/> PPO RM-34		<input type="checkbox"/> Decline Medical	
Select Enrollees: (per paycheck cost)			
<input type="checkbox"/> Employee Only (\$53.81)	<input type="checkbox"/> Employee/Children (\$216.84)		
<input type="checkbox"/> Employee/ Spouse (\$318.75)	<input type="checkbox"/> Employee/Family (\$481.80)		

MEDICAL OPTION #3: <input type="checkbox"/> HSA RMH-3		<input type="checkbox"/> Decline Medical	
Select Enrollees: (per paycheck cost)			
<input type="checkbox"/> Employee Only (\$61.83)	<input type="checkbox"/> Employee/Children (\$231.29)		
<input type="checkbox"/> Employee/ Spouse (\$337.19)	<input type="checkbox"/> Employee/Family (\$506.66)		

DENTAL: <input type="checkbox"/> D201		<input type="checkbox"/> Decline Dental	
Select Enrollees: (per paycheck cost)			
<input type="checkbox"/> Employee Only (\$10.34)	<input type="checkbox"/> Employee/Children (\$21.30)		
<input type="checkbox"/> Employee/ Spouse (\$21.86)	<input type="checkbox"/> Employee/Family (\$33.66)		

List Dependents to be enrolled:

Name	Gender	Relationship	Date of Birth	Social Security Number	Home Address if different from employee's
		Spouse			
		Child			
		Child			
		Child			
		Child			
		Child			

Term Life and AD&D Insurance – Free \$15,000 for Full Time Employee taking Health Insurance.

Please list your beneficiaries. (Name, address, Relationship)

Primary Beneficiary:

Contingent Beneficiary:

(Life and AD&D benefits reduce by 35% of the original amount at age 65, and further reduce to 50% at age 70)

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Reason for Application: Open Enrollment Divorce Marriage Birth Adoption

Date of Event: _____

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 for you and any dependents listed. If you have a certificate of prior coverage, please attach a copy of this to the enrollment application.

Name of Primary Enrollee: _____

Employer's Name: _____ Group Policy # _____

Name and address of other insurance company:

Effective Date of Coverage _____ Cancellation Date _____

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.

Reason for Declining:

Employee: Other Group Coverage Medicare Medicaid Other, Explain _____

Spouse: Other Group Coverage Medicare Medicaid Other, Explain _____

Children: Other Group Coverage Medicare Medicaid Other, Explain _____

COVERAGE CONDITIONS:

I am a Full Time employee of Angels of Care. 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 or Dearborn National Life Insurance Company. On behalf of myself and any dependent(s) 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.

- 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 will become effective in accordance with the provisions of the Contract Plans.
- I understand that the Health coverage for which I am applying may have a pre-existing condition exclusion waiting period.
- I agree that my Employer acts as my agent. I authorize necessary payroll deductions by my Employer, if any to cover the cost of my coverage.
- I understand that payroll deductions by my Employer will be pre-tax deductions, per Section 125 of the Plan Document.
- I understand that my participating in the coverage is subject to any future amendments. I also understand that all notices given to my Employer are binding upon me.

Applicant's Signature _____ Date _____