

PLEASE PRINT CLEARLY

<input type="checkbox"/> New Enrollment		<input type="checkbox"/> Change in Coverage		Shaded Area for Office Use Only C P <input type="checkbox"/> YES <input type="checkbox"/> NO		Approval		Effective Date				
Monthly	Bi-Weekly	Last Name		First	Middle		Sex <input type="checkbox"/> Male <input type="checkbox"/> Female		Social Security No.			
Date of Birth Mo Day Yr		Date of Employment Mo Day Yr		Campus/Dept.								
Home Address - No. and street Name								City	State	ZIP	Home Telephone No. ()	

<input type="checkbox"/> Change Name	<input type="checkbox"/> Cancel Coverage	<input type="checkbox"/> Change Health Selection from _____ to _____	
<input type="checkbox"/> Add Dependent(s)*	<input type="checkbox"/> Drop Dependent(s)*	<input type="checkbox"/> Change Primary Care Physician (Indicate Below) *List dependent information below.	

2 Check Reason For Change And Show Date Of Event: (Please complete Section 6 below.) Dependent Child Becomes Eligible/Ineligible _____

Birth of Child _____ Marriage _____ Spouse Begins/Ends Employment _____ Other _____

Adoption _____ Divorce _____ Deceased _____ Loss of other Coverage _____

SELECT ONE COVERAGE OPTION

<input type="checkbox"/> BlueChoice Low Option (PPO) (Group #93748) <input type="checkbox"/> I apply <input type="checkbox"/> I do not apply <input type="checkbox"/> Single Coverage <input type="checkbox"/> Dependent Coverage	<input type="checkbox"/> BlueChoice High Option (PPO) (Group #93748) <input type="checkbox"/> I apply <input type="checkbox"/> I do not apply <input type="checkbox"/> Single Coverage <input type="checkbox"/> Dependent Coverage	<input type="checkbox"/> HMO Blue® Texas (Group # 93748P) <input type="checkbox"/> I apply <input type="checkbox"/> I do not apply <input type="checkbox"/> Single Coverage <input type="checkbox"/> Dependent Coverage <i>PCP Selection Required</i>	<input type="checkbox"/> Hospital Indemnity (Employees Only) Declining Health Coverages
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IMPORTANT

(1) Include address and ZIP of dependent(s) residing outside of household.
 (2) A child of the employee's child can be listed as a dependent, only if IRS guidelines are met.
 (3) Stepchildren can be listed as dependents only if the employee's address is their primary residence.
 (4) A court-ordered dependent child is eligible.
 (5) A child who is other than (1) a natural or adopted child, (2) a court ordered dependent child, or (3) a child of the employee's child, can be listed if the child meets IRS support guidelines and resides with the employees.
 (6) If adding a student or disabled child who exceeds the age limit in your Employer's contract and meets IRS support guidelines, complete the Over Age Dependent information below.

Applicant's Primary Care Physician (PCP) Name		PCP I.D. #	New Patient? <input type="checkbox"/> Y <input type="checkbox"/> N
PCP _____ (For HMO Blue Participants only)		_____	

Dependent's Full Name <input type="checkbox"/> Husband <input type="checkbox"/> Wife	Date of Birth Mo Day Yr	Dependent's PCP Name	PCP I.D. #	New Patient? <input type="checkbox"/> Y <input type="checkbox"/> N
_____	_____	PCP _____ (For HMO Blue Participants only)	_____	

3 Dependent's Social Security No. _____ Home Address, if different - No. and Street Name _____ City _____ State _____ Zip _____

Dependent's Full Name <input type="checkbox"/> Son <input type="checkbox"/> Daughter	Date of Birth Mo Day Yr	Dependent's PCP Name	PCP I.D. #	New Patient? <input type="checkbox"/> Y <input type="checkbox"/> N
_____	_____	PCP _____ (For HMO Blue Participants only)	_____	

Dependent's Social Security No. _____ Home Address, if different - No. and Street Name _____ City _____ State _____ Zip _____

Dependent's Full Name <input type="checkbox"/> Son <input type="checkbox"/> Daughter	Date of Birth Mo Day Yr	Dependent's PCP Name	PCP I.D. #	New Patient? <input type="checkbox"/> Y <input type="checkbox"/> N
_____	_____	PCP _____ (For HMO Blue Participants only)	_____	

Dependent's Social Security No. _____ Home Address, if different - No. and Street Name _____ City _____ State _____ Zip _____

Dependent's Full Name <input type="checkbox"/> Son <input type="checkbox"/> Daughter	Date of Birth Mo Day Yr	Dependent's PCP Name	PCP I.D. #	New Patient? <input type="checkbox"/> Y <input type="checkbox"/> N
_____	_____	PCP _____ (For HMO Blue Participants only)	_____	

Dependent's Social Security No. _____ Home Address, if different - No. and Street Name _____ City _____ State _____ Zip _____

4 **Beneficiary Information for Basic Group Term Life Insurance - \$10,000 (Available for Active Employees Only)**

Primary Beneficiary	Full Name	Relationship	Date of Birth
Contingent Beneficiary	Full Name	Relationship	Date of Birth

5 **Other Coverage Information** Are you or any member of your family listed above as dependents covered by any other health coverage? Yes No

Group Coverage <input type="checkbox"/> Yes <input type="checkbox"/> No	Name of Other Company	Address of Other Company
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Name of Policyholder	Date of Birth	<input type="checkbox"/> Male <input type="checkbox"/> Female	Relationship to Applicant <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent	Type of Coverage <input type="checkbox"/> Self <input type="checkbox"/> Two Person <input type="checkbox"/> Family
ID Number	Effective Date of Coverage	Group or Policy Number	Employer's Name	

6 **Special Enrollment Event** Name of Person(s) _____ Special Enrollment Event Date _____ Reason _____

7 **Medicare Coverage Information** Please check the reason for Medicare Eligibility: Entitled Age End-Stage Renal Disease Disability and Current Renal Disease

Name of Person Covered	<input type="checkbox"/> Medicare A (Hospital) Effective Date _____	Medicare No. (From Medicare Card)
_____	<input type="checkbox"/> Medicare B (Medical) Effective Date _____	_____

8 **Over Age Dependent Information** Name of student or disabled dependent _____

Date enrolled as a full-time student _____ Name and Address of School _____

Nature of Disability _____ Is child unable to work due to disability? Yes No

Has disability been diagnosed as permanent? Yes No If temporary, how long is child expected to remain disabled? _____

I am an employee of North East Independent School District. I am eligible to participate in the coverage(s) afforded by my Employee Benefit Plan, which is either underwritten or administered by Blue Cross and Blue Shield of Texas, Inc. (BCBSTX) and Fort Dearborn Life Insurance Company (FDL) (Companies). On behalf of myself and any dependents listed on this Application, I apply for those coverage(s) for which I am eligible. I state that the information given on my 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 Application is accepted, the coverage(s) will become effective in accordance with the provisions of the coverage(s).

I authorize my Employer to deduct from my wages or salary, any of the contributions as they become due. I agree that my Employer acts as my agent. All notices given to it are binding upon me. I also agree that my participation in the coverage(s) is subject to any future amendments. I understand no agent can: (1) accept risks, or (2) modify documents, or (3) waive any right or requirements.

I authorize any hospital, physician, dentist, provider, insurance carrier, or other entity to give the Companies, upon request, any information covering the health condition of any person included under the coverage(s) whenever the information is considered necessary by the Companies for proper disposition of the Application or of a claim submitted for payment.

I understand that (1) the health coverage I am applying for may be subject to a Preexisting Condition exclusion for a period of time as specified in the Employee Benefit Plan Document issued by my Employer; and (2) Preexisting Condition means any abnormal physical or mental condition, whether active or inactive, including pregnancy, which caused the Participant to receive medical advice or be treated by a medical practitioner during the period specified in the Employee Benefit Plan Document, insurance policy or benefit contract immediately preceding the effective date of the Participant's coverage, including all deformities, ailments or prior injuries.

Please see reverse side of this form for important information on your COBRA and HIPAA rights.

Applicant's Signature _____ Date _____

White Copy: Employee Benefits Yellow Copy: Employee