BlueCross BlueShield of Texas

Enrollment and Change Form

Administrative Offices: 701 E. 22nd Street, Lombard, IL 60148

BENEFIT SELECTION - VISION

ENROLLMENT	POLICY CHANGE	CANCEL COVERAGE
Spouse includes Domestic Partner and Party to a Civil Union as defined in the Certificate. *(Choose One)* ☐ Employee ☐ Employee + Spouse ☐ Employee + Child(ren) ☐ Family	*(Check Reason for Change)* ☐ Married ☐ Birth / Adoption ☐ Widowed ☐ Divorced ☐ Address Change	☐ Terminate Coverage Date / / ☐ Leave / Layoff ☐ Other Date / /

COBRA CONTINUATION PRIVILEGE

Start Date: / /

Projected End Date: / /

Previously covered with group as:

☐ 1. Employee (termination, reduction in hours, other)

☐ 2. Spouse (divorce from employee, death of employee)

☐ 3. Dependent (reached age limit, married, no longer a Full Time Student, other)

☐ 4. Spouse & Dependents (divorce from employee, death of employee, other)

For the purposes of this Notice, while prohibited by Federal law, Spouse does not include a same-sex Domestic Partner or Party to a Civil Union. Such benefits may be available under state law if provided by the policyholder.

COVERED SPOUSE AND DEPENDENTS

Dependent Child(ren) over the age limit, indicate if Full Time Student (FTS) or Handicapped (HDCP).

First Name Last Name	Social Security Number	Date of Birth	Relationship	SEX	Adult Child FTS or HDCP	Name of Accredited School
			SPOUSE	☐ M ☐ F		
				☐ M ☐ F		
				☐ M ☐ F		
				☐ M ☐ F		
				☐ M ☐ F		
				☐ M ☐ F		

I hereby request to be insured and authorize deductions, if any, from my compensation for my share of the cost of the benefits to which I may be entitled under the group policy (ies) issued to the employer listed above. I understand that if I am not actively at work on the effective date of my coverage, my insurance will not begin until the day I return to work. I understand that if I do not remain actively at work that my coverage may lapse or terminate. For those coverages I have declined, I understand that if I choose to enroll at a later date, my cost may be higher and a health questionnaire may be required.

FOR OFFICE USE ONLY

EMPLOYEE SIGNATURE _____ DATE / /

Waiver of Coverage:

I DO NOT WISH TO ENROLL at this time and understand that the opportunity to enroll at any future time will be subject to such arrangements as may be made with the company.

EMPLOYEE SIGNATURE _____ DATE / /

EMPLOYER
JULY BUSINESS SERVICES

EMPLOYEE NAME - LAST FIRST