



RETIREE OPEN ENROLLMENT

North East ISD Notice of Enrollment or Change in Health Coverage

PLEASE PRINT CLEARLY



1	<input type="checkbox"/> New Enrollment	<input type="checkbox"/> Change in Coverage	Notification Date To BCBS	Approval	Effective Date January 1, 2013
Date of Birth		Last Name		First Name	
				Middle	
Social Security Number:					
Home Address – No. and Street Name			City	State	Zip Code
				Telephone #	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female

2	<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)*			
*Select one coverage category below and (if applicable) list eligible dependent(s)					
<input type="checkbox"/> Employee Only		<input type="checkbox"/> Employee + Spouse		<input type="checkbox"/> Employee + Child(ren)	
<input type="checkbox"/> Employee + Family					
SELECT ONE COVERAGE OPTION					
<input type="checkbox"/> BlueChoice Low Option (PPO) (Group # 93748)		<input type="checkbox"/> BlueChoice High Option (PPO) (Group #93748)		<input type="checkbox"/> HMO Blue Texas* (Group #93748P)	

Applicant's Primary Care Physician (PCP) Name	PCP I.D./NPI #
*(For HMO Blue Participants Only)	

3	Dependent Information: Full Name:	Relationship: <input type="checkbox"/> Spouse <input type="checkbox"/> Child	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Dependent's PCP Name _____ *(For HMO Blue Participants Only)	PCP I.D./NPI # _____
Dependent's SSN		Date of Birth		Home Address (If different): No. and Street Name City State Zip Code	
Dependent Information: Full Name:		Relationship: <input type="checkbox"/> Spouse <input type="checkbox"/> Child		Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	
Dependent's SSN		Date of Birth		Home Address (If different): No. and Street Name City State Zip Code	
Dependent Information: Full Name:		Relationship: <input type="checkbox"/> Spouse <input type="checkbox"/> Child		Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	
Dependent's SSN		Date of Birth		Home Address (If different): No. and Street Name City State Zip Code	
Dependent Information: Full Name:		Relationship: <input type="checkbox"/> Spouse <input type="checkbox"/> Child		Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	
Dependent's SSN		Date of Birth		Home Address (If different): No. and Street Name City State Zip Code	

I am a COBRA participant 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). 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 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.

A child of an employee 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 as a dependent, if the child meets IRS guidelines and resides with the employee. Stepchildren can be listed as dependents only if the employee's address is their primary residence.

Applicant's Signature _____ **Date** _____