BlueCross BlueShield of Texas

Employee Enrollment / Change Form

☐ Initial Group ☐ Open Enrollment
☐ New Employee ☐ Change (complete change section)

Benefits administered by:
Blue Cross and Blue Shield of Texas

EMPLOYER NAME | GROUP NUMBER | HIRE DATE | EFFECTIVE DATE

Kickapoo Employee Benefit Plan | **432017** | | |

EMPLOYEE LOCATION

☐ 001 Tribe ☐ 003 Casino ☐ 005 Comfort Inn Tribal
☐ 002 Comfort Inn ☐ 004 Tribe Tribal ☐ 006 Casino Tribal

SOCIAL SECURITY NUMBER ____ - ____ - ____ | DEPARTMENT _____ | TRIBAL STATUS ☐ Tribal ☐ Non-Tribal

LAST NAME _____ | FIRST NAME _____ | M.I. _____

ADDRESS _____ | CITY _____ | STATE _____ | ZIP _____ | EMAIL ADDRESS _____

DATE OF BIRTH _____ | GENDER ☐ M ☐ F | MARITAL STATUS _____ | HOME TELEPHONE NUMBER _____

OTHER HEALTH INSURANCE INFORMATION

Do you or any family member currently have other health coverage? ☐ Yes, single ☐ Yes, family ☐ No

If yes to the above question, complete the following:

Person's Name _____ Employer Name _____

Carrier Name _____ Plan Number _____

PLAN AND TIER ELECTIONS

Medical Plan: ☐ Tribal PPO Plan ☐ Non-Tribal PPO Plan

Coverage level: ☐ Employee ☐ Employee + Spouse ☐ Employee + Child(ren) ☐ Family

WAIVING COVERAGE: ☐ I freely and voluntarily waive all coverage noted above.

	LAST FIRST MI	SS#	BIRTH DATE	GENDER	RELATIONSHIP
Spouse's Name		___-___-___		☐ F ☐ M	Relationship: ☐ Tribal ☐ Non-Tribal
Child's Name 1.		___-___-___		☐ F ☐ M	Relationship: ☐ Tribal ☐ Non-Tribal
Child's Name 2.		___-___-___		☐ F ☐ M	Relationship: ☐ Tribal ☐ Non-Tribal
Child's Name 3.		___-___-___		☐ F ☐ M	Relationship: ☐ Tribal ☐ Non-Tribal

I certify the information provided is true and correct. I understand that coverage begins only after all eligibility questions are resolved. Coverage elections may not be changed until the next open enrollment period or as otherwise allowed by the Plan.

Please refer to your Employee Benefit Booklet for full plan details.

_____ EMPLOYEE SIGNATURE

_____ DATE