

ENROLLMENT APPLICATION/CHANGE FORM

Medical and/or Group Term Life Insurance

| | | |
|----------------|--------------------|--------------|
| Group #: 24220 | Social Security #: | Baylor ID #: |
|----------------|--------------------|--------------|

| | | |
|---|--|---|
| <p>Section 1 – Enrollment Events</p> <p><input type="checkbox"/> New Enrollee or <input type="checkbox"/> Add Dependent List names of dependents to be added in section 4 below.</p> <p>Indicate Effective Date: _____</p> <p>Add Coverage: Health</p> | <p style="text-align: center;">Cancel Dependent List names of dependent(s) to be canceled in section 4 below. Do not list active dependents.</p> <p>Indicate Effective Date: _____</p> <p style="text-align: center;">Change Address/Name Declination of Medical Coverage (refer to section 10)</p> | <p>Are you applying as a result of a special enrollment event? Yes No</p> <p>If yes, select below:</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>If other is selected, please explain:</p> |
|---|--|---|

Section 2 – Please tell us about yourself

| | | | | |
|--|------------------------------|--|-------------------------|-------------------|
| First Name | Middle | Last | Birth Date (mm/dd/yyyy) | |
| | | | | |
| Gender Male Female | Employment Date (mm/dd/yyyy) | Name of Employer Baylor University | | Work Phone Number |
| | | | | |
| Home Address – Street address City State Zip | | | | Home Phone Number |
| | | | | |

Section 3 – Select your medical coverage option

Medical (Select Option)

Employee only Employee + Spouse Employee + Children Employee + Family I do not apply

Section 4 – Spouse & dependent children to be covered/or canceled (Dependent unmarried children to age 26)

| Name: First, Initial, Last | Relation: (Spouse or Child) | Sex | Date of Birth (mm/dd/yyyy) | Social Security Number | Home address if different |
|----------------------------|--------------------------------|--|-------------------------------|------------------------|---------------------------|
| | | <input type="checkbox"/> M <input type="checkbox"/> F | | | |
| | | <input type="checkbox"/> M <input type="checkbox"/> F | | | |
| | | <input type="checkbox"/> M <input type="checkbox"/> F | | | |
| | | <input type="checkbox"/> M <input type="checkbox"/> F | | | |
| | | <input type="checkbox"/> M <input type="checkbox"/> F | | | |
| | | <input type="checkbox"/> M <input type="checkbox"/> F | | | |
| | | <input type="checkbox"/> M <input type="checkbox"/> F | | | |

Section 5 – Group Term Life Insurance

| | | | | | |
|------------------------|------------|---------|-----------|--------------|---------------|
| Primary Beneficiary | First Name | Initial | Last Name | Relationship | Date of Birth |
| | | | | | |
| Contingent Beneficiary | First Name | Initial | Last Name | Relationship | Date of Birth |
| | | | | | |

Last Name: _____

SS#: _____

Group#: 24220

SECTION 6 — PREVIOUS HEALTH 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 to this enrollment application. (If more than one plan was in effect, or if information is different for dependents, attach additional pages.) If Medicare, please complete the Medicare Coverage Information in Section 8 below. **List names of every individual covered:**

| | | | | | |
|--|-----------------------|--|---|---|------|
| Name of Primary enrollee | Birth Date | <input type="checkbox"/> Male <input type="checkbox"/> Female | Relationship to Applicant <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent | Group # | ID # |
| Employer's Name: | Employment Date _____ | Type of Coverage: <input type="checkbox"/> Employer <input type="checkbox"/> Sponsored <input type="checkbox"/> Individual <input type="checkbox"/> Purchase | | Type of Policy <input type="checkbox"/> Self <input type="checkbox"/> Family <input type="checkbox"/> Employee/Spouse <input type="checkbox"/> Employee/Child | |
| Name and Address of other Insurance Co | Effective Date _____ | Will Coverage be continued? <input type="checkbox"/> Yes <input type="checkbox"/> No | | If No, Expected Cancel Date _____ | |

Section 7 – Other Continued Health Coverage Information

Are you or any member of your family listed above covered by any other group health coverage? Yes No List names of individuals covered:

| | | | | | |
|---|---|--|---|---|--|
| Group Coverage <input type="checkbox"/> Yes <input type="checkbox"/> No | Name and Address of Other Health Care Company | | | | |
| Name of Policy Holder | Birth date (Mo Day Yr) | <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 | Employment Date | Effective Date of Coverage | Group # | Employer's Name | |

Section 8 – Medicare Coverage Information

| | | |
|--|--|---------------------------------|
| Name of person covered: | Medicare A (Hospital) Effective Date: _____ Medicare B (Hospital) Effective Date: _____ | Medicare # (from Medicare Card) |
| Check reason for Medicare: <input type="checkbox"/> Entitled age <input type="checkbox"/> Entitled disability <input type="checkbox"/> End-stage renal disease <input type="checkbox"/> Disability and current renal disease | | |
| Name of person covered: | <input type="checkbox"/> Medicare A (Hospital) Effective Date: _____ <input type="checkbox"/> Medicare B (Hospital) Effective Date: _____ | Medicare # (from Medicare Card) |
| Check reason for Medicare: <input type="checkbox"/> Entitled age <input type="checkbox"/> Entitled disability <input type="checkbox"/> End-stage renal disease <input type="checkbox"/> Disability and current renal disease | | |

Section 9 – Disabled Dependent

| | |
|---|-----------------------|
| Name of Disabled Dependent: | Nature of Disability: |
| Has disability been diagnosed as permanent? <input type="checkbox"/> Yes <input type="checkbox"/> No If temporary, how long is child expected to remain disability? | |
| Is child unable to work due to the disability? <input type="checkbox"/> Yes <input type="checkbox"/> No | |

Section 10 – 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: Other Group Coverage Medicare Medicaid Other, explain: _____

Section 11 – Coverage Conditions

- I am an employee of the Employer named in this Enrollment Application. I am eligible to participate in the coverage(s) afforded by my Employer's plan. On behalf of myself and any dependents 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. 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 Enrollment Application is accepted, the coverage(s) will become effective in accordance with the provisions of the Contract(s).
- I understand that the health coverage I am applying for may be subject to a pre-existing condition exclusion).
- I authorize necessary payroll deduction by my Employer, if any, to cover the cost of my coverage(s). I agree that my Employer acts as my agent. All notices given to my Employer are binding upon me. I also agree that my participation in the coverage(s) is subject to any future amendments.

Applicant's Signature _____ Date _____