Texas Annual Conference
Group Health Benefits Enrollment Form

(Please print legibly)

For Office Use Only
Effective Date:
____

****Please note, this application has two (2) pages. Please complete, sign and date on page 2 of this application, or the document will not be valid.**

Employer: Texas Annual Conference of the United Methodist Church Group No.: 928

EMPLOYEE INFORMATION

Employee Name ______________________________ Preferred Name ________________
Last First Middle

Social Security No. ____________________ Date of Birth ____________________ Sex ____________

Marital Status: Single ☐ Married ☐ Widow/Widower ☐ Email ______________________________

Address ____
Street City State Zip

Work Phone ____________________ Cell Phone ____________________ Home Phone ____________________

Active Clergy ☐ Laity ☐ Medical Leave (not on Medicare) ☐ Medical Leave (Medicare Primary) ☐

Employed Full Time? Yes ☐ No ☐ Hours worked per week ______ Are you authorized to work in the US? Yes ☐ No ☐

MEDICAL BENEFITS ELECTION

Medical Benefits (check one): Standard PPO Plan ☐ or High Deductible PPO Plan ☐

I want **Medical** Benefits for: Employee Only ☐ Employee & Spouse ☐ Employee & Child(ren) ☐ Employee & Family ☐

OPTIONAL DENTAL BENEFITS ELECTION

Optional Dental Benefits (check one): Dental **PPO** ☐ Dental **HMO** ☐ I decline dental coverage ☐

I want **Dental** Benefits for: Employee Only ☐ Employee & Spouse ☐ Employee & Child(ren) ☐ Employee & Family ☐

For **Dental HMO** ***only***: **Dental HMO** Dentist Name ______________________________ Dentist ID No. ____________

Dental HMO Dentist Address, City, State, Zip ____

If you are electing dental coverage, please provide the following information:

Prior dental coverage in the past 12 months? Yes ☐ No ☐ Prior orthodontia coverage in the past 12 months? Yes ☐ No ☐

Prior dental insurance carrier name ____________________________ Start Date __________ End Date __________

Prior dental coverage type: Employee Only ☐ Employee & Spouse ☐ Employee & Child(ren) ☐ Employee & Family ☐

OPTIONAL VISION BENEFITS ELECTION

I elect **Optional Vision Benefits:** Yes ☐ No ☐

I want **Vision** Benefits for: Employee Only ☐ Employee & Spouse ☐ Employee & Child(ren) ☐ Employee & Family ☐

DEPENDENT COVERAGE

I want to provide coverage for the following dependents as indicated by my plan elections above:

Spouse ____________________________ SS# ________________ Date of Birth ______________ Sex ________

Child ____________________________ SS# ________________ Date of Birth ______________ Sex ________

Child ____________________________ SS# ________________ Date of Birth ______________ Sex ________

Child ___________________________________ SS# ____________________ Date of Birth _________________ Sex ________

Child ___________________________________ SS# ____________________ Date of Birth _________________ Sex ________

Child ___________________________________ SS# ____________________ Date of Birth _________________ Sex ________

Child ___________________________________ SS# ____________________ Date of Birth _________________ Sex ________

(If you have more than 6 dependent children, give the total number here: __________, and provide their full names, social security numbers, dates of birth and sex on the back of this form.)

RGO#191 TERM LIFE / AD&D INSURANCE BENEFICIARIES

Designation of Primary Beneficiary(ies)** for your employee Term Life / AD&D benefits provided as part of your Group Health Benefits Plan. For **Relationship**: Designate "spouse," "child," "legal dependent," "estate," "trust," "organization," or "other." For **Percentage:** Specify a whole number. Percentages must total 100% - or write "equal" if you want your primary beneficiaries to share equally.

Name ____ SS# ____________________ Date of Birth _____________

Address ____ Relationship _________________ Percentage __________

Name ____ SS# ____________________ Date of Birth _____________

Address ____ Relationship _________________ Percentage __________

Name ____ SS# ____________________ Date of Birth _____________

Address ____ Relationship _________________ Percentage __________

****Signature of Spouse is required only if Primary Beneficiary designation(s) is someone other than your spouse.***

Spouse's Signature ____ Date _______________________

Designation of Secondary Beneficiary(ies):
For **Relationship**: Designate "spouse," "child," "legal dependent," "estate," "trust," "organization," or "other."
For **Percentage:** Specify a whole number. Percentages must total 100% - or write "equal" if you want your primary beneficiaries to share equally.

Name ____ SS# ____________________ Date of Birth _____________

Address ____ Relationship _________________ Percentage __________

Name ____ SS# ____________________ Date of Birth _____________

Address ____ Relationship _________________ Percentage __________

Name ____ SS# ____________________ Date of Birth _____________

Address ____ Relationship _________________ Percentage __________

AUTHORIZATION

Your signature completes the enrollment process. It authorizes the benefits to be provided and the beneficiary designation(s) indicated. It also authorizes the appropriate electronic funds transfers or payroll deductions to provide the coverages requested.

Participant's Signature ____ Date ____________________________

TO BE COMPLETED BY TAC BENEFITS OFFICE

AUL Group Policy No. 00030793-0000-000 Class No. ______ Occupation ______________ Date Hired Full Time _____________

Return completed, signed form to:

Texas Annual Conference Benefits Office
5215 Main St., Houston, TX 77002
Fax: 713-521-7516 Email: atbertrand@txcumc.org
Phone: 713-533-3723 or 1-800-606-0350