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.: 002928

EMPLOYEE INFORMATION

Employee Name _____
First **Middle** **Last** **Suffix**

Preferred Name _____ Sex _____ Social Security No. _____ Date of Birth _____

Marital Status: Single _____ Married _____ Email _____

Home Address _____
Street City State Zip

Cell Phone _____ Work Phone _____ Home Phone _____

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

Employed Full Time? Yes _____ No _____ Hours worked per week _____ Authorized to work in the US? Yes _____ No _____

Select your Benefit Plans below. Note: You can have a different coverage election for each plan if desired.

MEDICAL BENEFITS ELECTION

Medical Benefits Plan (check ***one***):	**Standard PPO Plan** _____	***or***	**High Deductible PPO Plan** _____
I elect **Medical** Benefits for (check ***one***):	Employee Only _____		Employee Only _____
	Employee & Spouse _____		Employee & Spouse _____
	Employee & Children _____		Employee & Children _____
	Employee & Family _____		Employee & Family _____

OPTIONAL DENTAL BENEFITS ELECTION

I elect Optional **Dental PPO** Benefits for (check ***one***): Employee Only _____ ***or*** **I decline dental coverage** _____

Employee & Spouse _____

Employee & Children _____

Employee & Family _____

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

Prior dental coverage in the past 12 months? Yes ____ No ____ Orthodontia coverage in the past 12 months? Yes ____ No _____

Prior dental insurance carrier name _____ Start Date _____ End Date _____

Prior dental coverage: Employee Only _____ Employee & Spouse _____ Employee & Children _____ Employee & Family _____

OPTIONAL VISION BENEFITS ELECTION

I elect Optional **Vision** Benefits for (check ***one***): Employee Only _____ ***or*** **I decline vision coverage** _____

Employee & Spouse _____

Employee & Children _____

Employee & Family _____

DEPENDENT COVERAGE

If an employee is covered by the plan, the employee's eligible dependents can also be covered. An eligible dependent is:

1. A spouse. Such spouse must have met all requirements of a valid marriage contract in the state of marriage.
2. A child under the age of 26 who is the employee's:
    a. natural child;
    b. legally adopted child or child placed in the home (in accordance with applicable law) awaiting the employee's adoption; or
    c. stepchild.
3. A child under the age of 18 where the employee is the child's:
    a. foster parent;
    b. legal guardian; or
    c. permanent managing conservator or court-appointed permanent custodial parent.
4. A newborn child of the covered employee for the first 31 days after birth.
5. An otherwise eligible child who is age 26 or over and incapable of self-support because of developmental or physical handicap that began before his or her 26th birthday. You must submit written evidence of the child's incapacity within 31 days of the later of the child's 26th birthday or your effective date, and either:
    a. the child is a beneficiary immediately before his or her 26th birthday; or
    b. the child's 26th birthday preceded your effective date and the dependent has been continuously covered as your dependent on a group coverage since that birthday.

I want to provide coverage for my following eligible dependents as per my benefit plan enrollments elected above:

Spouse Name _____
First **Middle** **Last** **Suffix**

Sex _____ *Social Security No.* _____ *Date of Birth* _____

Child Name _____
First **Middle** **Last** **Suffix**

Relationship _____ *Sex* _____ *Social Security No.* _____ *Date of Birth* _____

Child Name _____
First **Middle** **Last** **Suffix**

Relationship _____ *Sex* _____ *Social Security No.* _____ *Date of Birth* _____

Child Name _____
First **Middle** **Last** **Suffix**

Relationship _____ *Sex* _____ *Social Security No.* _____ *Date of Birth* _____

(If you have more than three (3) dependent children to enroll, give the total number here: _____, and complete and sign an additional copy of this page to provide their full names, relationship, sex, social security numbers, and dates of birth).

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

Division Code: 600_____ 700_____ 750_____ 950_____ 975_____ Date Hired Full Time _____

Return completed, signed form to: TAC Benefits Office Attn: Marianela Chinea
5215 Main St., Houston, TX 77002
Fax: 713-521-7516
Email: mchinea@txcumc.org
Direct: 713-533-3723

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