

Texas Annual Conference Group Health Benefits

Under 65 (<65) Retiree / Under 65 (<65) Spouse of Medicare Primary Participant Under 65 (<65) Surviving Spouse / Under 65 (<65) Other Dependent

Open Enrollment Form

For Office Use Only Effective Date: _____

Please Print Legibly.
Enrollment form must be signed and dated or it will not be valid.

Employer: Texas Annual Conference of the United Methodist Church

Group No.: 002928

PARTICIPANT INFORMATION

Participant Name _____

First	Middle	Last
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Social Security No. _____ Date of Birth _____ Sex _____

Marital Status: Single Married Widow/Widower Email _____

Address _____

Street	City	State	Zip
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Work Phone _____ Cell Phone _____ Home Phone _____

<65 Retiree <65 Surviving Spouse <65 Spouse of Medicare Primary Participant <65 Other Dependent

Employed? Yes No Hours worked per week _____ Employer _____

MEDICAL BENEFITS COVERAGE

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

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

OPTIONAL DENTAL COVERAGE

I elect **Optional Dental PPO** Benefits: Yes No

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

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: Participant Only Participant & Spouse Participant & Child(ren) Participant & Family

OPTIONAL VISION COVERAGE

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

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

DEPENDENT COVERAGE

I want to **continue** coverage for the following under age 65 dependents: **(No new dependents can be added)**

Spouse _____ SS# _____ Date of Birth _____ Sex _____

Child _____ SS# _____ Date of Birth _____ Sex _____

Child _____ SS# _____ Date of Birth _____ Sex _____

DEPENDENT COVERAGE CONTINUED (No new dependents can be added)

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 dependents, give the total number here: _____, and provide full names, social security numbers, dates of birth and sex of additional dependents at the bottom of this form.)

AUTHORIZATION

Your signature completes the enrollment process. It authorizes the coverages indicated. It also authorizes the appropriate electronic funds transfers to provide the benefits requested.

Participant's Signature _____ Date _____

Return completed, signed form to: TAC Benefits Office
5215 Main St., Houston, TX 77002
Attn: Patricia Goforth-Rakes
Fax: 713-521-7516
Email: pgrakes@txcumc.org
Phone: 713-533-3702