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 want **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

Optional Dental Benefits (check ***one***):	**Dental PPO** _____	***or***	**Dental HMO** _____	***or***	**I decline dental** _____
I want **Dental** Benefits for (check ***one***):	Employee Only _____		Employee Only _____		
	Employee & Spouse _____		Employee & Spouse _____		
	Employee & Children _____		Employee & Children _____		
	Employee & Family _____		Employee & Family _____		

For **Dental HMO** ***only***: **Dental HMO** Dentist Name _____ Dentist ID No. _____

Dental HMO Dentist Address: _____
Street City State Zip

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 type (check one):	Employee Only _____	Employee & Children _____
	Employee & Spouse _____	Employee & Family _____

OPTIONAL VISION BENEFITS ELECTION

I elect **Optional Vision Benefits** (check ***one***): **Yes** _____ **I decline vision coverage** _____

I want **Vision** Benefits for (check ***one***):

Employee Only _____

Employee & Spouse _____

Employee & Children _____

Employee & Family _____

DEPENDENT COVERAGE

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

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

Sex _____ Social Security No. _____ Date of Birth _____

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

Sex _____ Social Security No. _____ Date of Birth _____

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

Sex _____ Social Security No. _____ Date of Birth _____

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

Sex _____ Social Security No. _____ Date of Birth _____

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

Sex _____ Social Security No. _____ Date of Birth _____

(If you have more than four (4) dependent children to enroll, give the total number here: _____, and use an additional copy of this page to provide their full names, 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
Ph: 713-533-3723