

**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 Retiree Surviving Spouse

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): PPO \$700 Deductible or PPO High Deductible

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: pgrakes@txcumc.org
 Phone: 713-533-3723 or 1-800-606-0350