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

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 ____________________

<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

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