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
Initial 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

PARTICIPANT INFORMATION

Participant 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 _____

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

Employed in retirement? 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 & Dependents ☐

OPTIONAL DENTAL / VISION COVERAGE (*No new coverage or dependents can be added*)

I want to ***continue*** my ***Dental PPO*** Plan: Yes ☐ No ☐ I want to ***continue*** my ***Vision*** coverage: Yes ☐ No ☐

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 _____

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 on the back 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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