Texas Annual Conference
Group Health Benefits Enrollment Form

For Active Clergy and TAC Fiscal Office Lay Employees

For Benefits Office Use Only
Effective Date:
_____

Please note that this enrollment form has three (3) pages. Please complete all sections and sign and date on page 3 of this form, or the document will not be valid.

SECTION 1: EMPLOYEE INFORMATION

Employee Name _____
First **Middle** **Last** **Suffix**

Please note that the employee's name above must match the name on the Social Security card.

Preferred Name _____ Sex _____ SSN _____ Date of Birth _____

Marital Status: Single _____ Married _____ Email _____

Home Address _____
Street City State Zip

Cell Phone _____ Work Phone _____ Home Phone _____

Active Clergy ____ Laity ____ Employed Full Time (working 30+ hrs.)? Yes _____ No _____ 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.

SECTION 2: MEDICAL BENEFITS

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

I elect **Medical** Benefits Coverage for (check ***one***):

Employee Only _____ Employee & Spouse _____ Employee & Children _____ Employee & Family _____

SECTION 3: OPTIONAL DENTAL BENEFITS ELECTION

I elect Optional **Dental PPO** Benefits for (check ***one***): Employee Only _____ ***or*** **I decline dental coverage** _____

Employee & Spouse _____

Employee & Children _____

Employee & Family _____

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: Employee Only _____ Employee & Spouse _____ Employee & Children _____ Employee & Family _____

SECTION 4: OPTIONAL VISION BENEFITS ELECTION

I elect Optional **Vision** Benefits for (check ***one***): Employee Only _____ ***or*** **I decline vision coverage** _____

Employee & Spouse _____

Employee & Children _____

Employee & Family _____

SECTION 5: DEPENDENT COVERAGE

If an employee is covered by the plan, the employee's eligible dependents can also be covered. An eligible dependent is:

1. A spouse. Such spouse must have met all requirements of a valid marriage contract in the state of marriage.
2. A child under the age of 26 who is the employee's:
    a. natural child;
    b. legally adopted child or child placed in the home (in accordance with applicable law) awaiting the employee's adoption; or
    c. stepchild.
3. A child under the age of 18 where the employee is the child's:
    a. foster parent;
    b. legal guardian; or
    c. permanent managing conservator or court-appointed permanent custodial parent.
4. A newborn child of the covered employee for the first 31 days after birth.
5. An otherwise eligible child who is age 26 or over and incapable of self-support because of developmental or physical handicap that began before his or her 26th birthday. You must submit written evidence of the child's incapacity within 31 days of the later of the child's 26th birthday or your effective date, and either:
    a. the child is a beneficiary immediately before his or her 26th birthday; or
    b. the child's 26th birthday preceded your effective date and the dependent has been continuously covered as your dependent on a group coverage since that birthday.

I want to provide coverage for my following eligible dependents as per my benefit plan enrollments elected above:

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

Please note that the spouse's name above must match the name on the Social Security card.

Sex _____ *SSN* _____ *Date of Birth* _____ *Cell Ph.*_____

Spouse Email _____

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

Please note that the child's name above must match the name on the Social Security card.

Relationship _____ *Sex* _____ *SSN*_____ *Date of Birth* _____

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

Please note that the child's name above must match the name on the Social Security card.

Relationship _____ *Sex* _____ *SSN*_____ *Date of Birth* _____

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

Please note that the child's name above must match the name on the Social Security card.

Relationship _____ *Sex* _____ *SSN*_____ *Date of Birth* _____

(If you have more than three (3) dependent children to enroll, give the total number here: _____, and complete and sign an additional copy of this page to provide their full names, relationship, sex, SSNs, and dates of birth).

SECTION 6: ADDITIONAL MEDICAL INSURANCE INFORMATION: To be completed by all employees with enrolled dependents.

1. Are **you** covered by any other medical insurance? Yes _____ No _____

   If you answered "No" to question number 1, please move to question number 2.

   If you answered "Yes" to question number 1, please complete the following:

   Other Medical Insurance Carrier Name: _____ Effective Date: _____

   Other Medical Insurance Phone #: _____

2. Are any of **your enrolled family members** covered by other medical insurance? Yes_____ No_____

   If you answered "No" to question number 2, please sign and date and return this form.

   If you answered "Yes" to question number 2, please complete the following:

   Other Medical Insurance Policy Holder's Name: _____

   Other Medical Insurance Policy Holder's ID: _____ Policy Holder's Date of Birth: _____

   Other Medical Insurance Policy Holder's Effective Date of Coverage: _____

   Other Medical Insurance Carrier's Name: _____

   Other Medical Insurance Carrier's Phone #: _____

Enrolled Dependent Name(s)	Covered by the Other Medical Insurance listed above?	
a.	Yes	No
b.	Yes	No
c.	Yes	No
d.	Yes	No

SECTION 7: AUTHORIZATION

Your signature completes the enrollment process. It authorizes the benefits to be provided as indicated above. It also authorizes the appropriate electronic funds transfers or payroll deductions to provide the coverages requested. Please note that an electronic signature is acceptable.

Employee's Signature _____ Date _____

Please return completed, signed form, preferably by email to:

TAC Benefits Office, 5215 Main St., Houston, TX 77002
Attn: Marianela Morales
Fax: 713-521-7516
Email: mmorales@txcumc.org

TO BE COMPLETED BY TAC BENEFITS OFFICE

Division Code: 600_____ 700_____ 750_____ 950_____ 975_____ Date Hired Full Time _____

Rev. 10-9-2023