Texas Annual Conference
U65 Retiree, U65 Spouse of Medicare Primary, U65 Surviving Spouse, U65 Other Dependent

For Benefits Office Use
Effective Date:
_____

Group Health Benefits Initial Enrollment Form
(Please print legibly)

***Please Print Legibly*.**
Enrollment form must be signed and dated or it will not be valid.

SECTION 1: PARTICIPANT INFORMATION

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 _____

SECTION 2: MEDICAL BENEFITS COVERAGE

Medical Benefits (check one): Standard PPO Plan ☐ High Deductible PPO Plan ☐

I want **Medical** Benefits for: Participant Only ☐ Participant & Dependents ☐

SECTION 3: OPTIONAL COVERAGES (DENTAL / VISION (*No new coverage or dependents can be added*)

I elect Optional **Dental PPO** Benefits for: Participant Only ☐ Participant & Dependents ☐ ***or*** **I decline Dental** ☐

I elect Optional **Vision** Benefits for: Participant Only ☐ Participant & Dependents ☐ ***or*** **I decline Vision** ☐

SECTION 4: DEPENDENT COVERAGE (*No new dependents can be added*)

I want to ***continue*** coverage for the following under age 65 dependents:

Spouse_____ 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.)

SECTION 5: 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
Email: pgrakes@txcumc.org / fax: 713-521-7516

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