BlueCross BlueShield of Texas

App
Social Secur
Member ID

Sign Up for a **2026 Health** for You and Your Family.

You can sign up with Blue Cross and Blue Shield of Texas, a Corporation, by visiting **BluePlanCompareTX.com**. If you a authorized agent, be sure to include your agent's informatic

Help us process your Application

If applying during Open Enrollment, leave page 3 blank except for name a a qualifying life event and are applying outside annual Open Enrollment. Check **bc** Special Enrollment Period before filling out this Application. To receive language or call **855-710-6984**.

BE SURE TO:

- Download and follow the Application Checklist at **bcbstx.com/app-checklist**
- Include name and SSN at the top of all 16 pages.
- Answer **all** questions that apply to you and any dependents.
  - Print all answers in **black ink**. Pencil will not be accepted.
  - Cross out **any answer you wish to change** and add your initials by the new
- Complete the Application for the Primary Applicant and all **current and new** d existing plan. If you need more dependent sections, please download and com any overflow page(s) when you submit your Application. See **bcbstx.com/mor**
- Include the **first month's payment**, or complete the payment details on page make monthly payments.

- Sign the Application everywhere a signature is required (pages 10, 11, 13, 14 ar
  don't use. Fax to **800-279-7419**.
  - If the primary applicant is a minor child, or an individual legally unable to sig
    representative should make all signatures.
- Once you have submitted your application you can track its progress and see w
  bcbstx.com/application-tracker. You will receive an email with an access co
  application has been received.

CONSUMER CHOICE DISCLOSURE

**You have the option to choose a Consumer Choice health care plan that, either in v
mandated health benefits normally required in evidences of coverage in Texas. Th
a more affordable health plan for you although, at the same time, it may provide y
those normally included as state-mandated health benefits in Texas. If you choose
consult with your insurance agent to discover which state-mandated health benef
See the full Consumer Choice Disclosure on page 14. BCBSTX offers one non-Consu**

What do you want to do?

Appli

- ☐ Become a **NEW** member.
- ☐ **CHANGE** my 2026 health plan.
- ☐ **ADD** a dependent to my current health plan.
  (You may add a newborn within 60 days of birth by calling 888-697-068

How we will contact you.

If you want to get information from us electronically, we must have your email adc
agree we may send your policy information electronically, such as policy ki
This electronic delivery will continue through any policy renewals or changes.

You can change to paper delivery at any time with no penalty. To make or change
you may:

- Update your preferences and contact information at **mybam.bcbstx.com**.

OR

- Call Customer Service at the number on your member ID card.

Your documents can be viewed or printed using your computer or mobile device.
versions of Chrome, Firefox, Microsoft Edge or Safari.

Will you use a reimbursement a

Are any of the applicants purchasing this plan using an Individual Coverage Health
(ICHRA) or a Qualified Small Employer Health Reimbursement Arrangement (QSEH

If yes, please complete the below.

Select one: ☐ **ICHRA** ☐ **QSEHRA**

Effective Date of the ICHRA or QSEHRA	**Monthly Contrib**

Employer Name

Signing up outside Open Enrollment?

Appli

If you are signing up during Open Enrollment, enter y then skip to the next page. You can also apply online

DO YOU QUALIFY FOR SPECIAL ENROLLMENT?

You may sign up for coverage during a Special Enrollment Period. An SEP is a chan

- **You must apply within 60 days before or after the qualifying life event,**
- Check more than one event if more than one happened to you.
- **You must give us valid proof of a qualifying life event with this Applicat**
  - BCBSTX will review this proof to confirm that you qualify for an SEP.
  - Without valid proof, we **cannot** process your form or sign you up for a healt
- Once your plan has been issued, your SEP cannot be re-used to apply for a diff

Details about documents you need to provide are at **bcbstx.com/sep**. Please cor call BCBSTX at **800-531-4456** for examples of proof we can accept.

☐ **1.** My dependent(s) and/or I lost Minimum Essential Coverage as of this date. Fo

- For reasons beyond my control (not including reasons like failure to pay my disregard on my part for the plan's rules).[1]
- Because I turned age 26.[1,2]
- Because the plan holder became eligible for Medicare.[1]
- Because the plan holder died.[3]
- Because I lost my job, I lost hours, my employer stopped making payments ended.[1]
- Because someone on my plan was legally separated or divorced.[1]
- Because my plan stopped covering people in my situation.[1]

☐ **2.** Because I got married on this date.[3]

☐ **3.** Because I had a baby, adopted a child, had a child placed with me for adoptic subject to a suit of adoption, took in a foster child, or was ordered to cover a court order as of this date.[3]

☐ **4.** Because there was a mistake when I signed up for my last health plan, or I ha previous health plan or issuer broke its contract with me as of this date.[3]

☐ **5.** Because someone on my plan had a change in income and lost advance payr credit, cost-sharing reductions, or Medicaid, or my last non-Marketplace plan as of this date.[1]

☐ **6.** Because I got new health plan options when I moved on this date.[1]

☐ **7.** Because my current plan ends on a date other than December 31, which is th

☐ **8.** Because my employer offered to help with the cost of coverage either throug Health Reimbursement Arrangement (ICHRA) or a Qualified Small Employer H Arrangement (QSEHRA). **Select one:** ☐ **ICHRA** ☐ **QSEHRA**

☐ **a.** My employer is newly offering participation in an ICHRA or QSEHRA as c

☐ **b.** I am a new employee and my employer is offering participation in an ICHRA

☐ **9.** Because of an allowed reason I do not see on this list that happened on this (Please work with your agent or contact our sales center at **800-531-4456**.)[1]

[1] You must apply within 60 days before or after the qualifying life event.
[2] A dependent covered under a parent's Marketplace plan has until December 31 o
[3] You must apply within 60 days after the qualifying life event.

Tell us about you.

Appli

(PLEASE ANSWER FOR **EVERY** PERSON TO BE COVERED.)

PRIMARY APPLICANT[1] (Who should be listed first on the healt

First Name	**Middle Initial**	**Last Name**

Social Security Number	**Sex** M F	**Date**

Do you prefer to speak a language other than English?	**Do you prefer to rea**
Y N If YES, what language? _____	Y N If YES, what la

Within the past six months, have you used tobacco?[2] 4 or more times per w
ceremonial uses Y N If YES, when did you last use tobacco? _____

Home Address	**City**

Mailing Address (if different than home address)	**City**

What is the best phone number to reach you?[3]

_____

By providing your mobile phone number on this Application, you agree to receive a
from BCBSTX, including from third-party vendors or providers directly contracted
provide additional information about health plan products, benefits and programs
mybam.bcbstx.com. Standard mobile phone and/or text message charges may a
will be recurring. Frequency will vary. Consent is not a condition of purchase or enr

Email Address[3,4]

Primary Care Provider	**10-character PCP ID**

See **FindADoctorTX.com** to find a PCP. If you do not list a PCP above, BCBSTX
plan service area. PCP assignment may delay arrival of your member ID card.
care for a PCP that is not on your member ID card or for care from a provider
PCPs and OB-GYNs on page 8.

OPTIONAL: If you are Hispanic/Latino, do you identify as any of the following?

☐ Mexican ☐ Mexican American ☐ Chicano ☐ Puerto Rican ☐ Cu

OPTIONAL: Are you or do you identify as any of the following? (check all th

☐ White ☐ Black or African American ☐ American Indian or Alaska Nati
☐ Filipino ☐ Japanese ☐ Korean ☐ Vietnamese ☐ Other Asia
☐ Guamanian or Chamorro ☐ Samoan ☐ Other Pacific Islander ☐ C

COMMUNICATIONS CONSIDERATIONS

Do you or any dependent(s) age 18 or older have a disability that makes it hard to

If so, please list their names here.

[1] **If you are adding one or more dependents to your existing plan, please com**
AND the Primary Applicant. Proof of ineligibility for Medicare is required if
[2] Age 21 and older for tobacco use.
[3] Age 18 and older for mail, phone and email.
[4] You **must** provide your email address if you want to get information electronically or i

Tell us about you.

Appli

(PLEASE ANSWER FOR **EVERY** PERSON TO BE COVERED.)

SPOUSE, PARTNER OR DEPENDENT CHILD[1,2] (Who else do you w

First Name	**Middle Initial**	**Last Name**

Relationship	**Social Security Number**

Do you prefer to speak a language other than English? ☐ Y ☐ N If YES, what language? _____	**Within the past six months, have** 4 or more times per week on average ☐ Y ☐ N If YES, when did you last use t

Mailing Address[4]	**City**

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If a dependent (other than spouse) is 26 or older, does dependent have a me
If YES, a Disabled Dependent Authorization Form is required. You can find the for

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[2] "Spouse" includes domestic partners. Non-spouse dependents can be up to age 26 coverage with BCBSTX.

[3] Age 21 and older for tobacco use.

[4] Age 18 and older for mail, phone and email (if different from the Primary Applicar

[5] You **must** provide your email address if you want to get information electronicall

Tell us about you.

Appli

(**DEPENDENTS**[1,2], continued)

First Name	Middle Initial	Last Name

Relationship	Social Security Number

Do you prefer to speak a language other than English? Y N If YES, what language? _____	Within the past six months, have 4 or more times per week on average Y N If YES, when did you last use t

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OB-GYN ACCESS

You may get OB-GYN services from your Primary Car

- You do not need a referral from your PCP to see an OB-GYN.
- HMO plans will cover your OB-GYN visits only if your OB-GYN is in
- You do not have to tell us your choice of OB-GYN before an OB-GY

Choose your health plan.

Appli

Your coverage will start on the 1st of the month, unless oth
Application must be received by BCBSTX within the defined

Please review your options below and **SELECT ONLY ONE OPTION:**

PLAN SELECTION	INDIVIDUAL DEDUCTIBLE
☐ **Blue Advantage Bronze HMO℠ 204**[1]	$6,000
☐ **Blue Advantage Bronze HMO℠ 301**[1]	$10,600
☐ **Blue Advantage Bronze HMO℠ 302**[1]	$8,300
☐ **Blue Advantage Bronze HMO℠ Standard**[1]	$7,500
☐ **Blue Advantage Silver HMO℠ 205**[1]	$1,450
☐ **Blue Advantage Silver HMO℠ 306**[1]	$1,600
☐ **Blue Advantage Silver HMO℠ 601**[1]	$2,500
☐ **Blue Advantage Silver HMO℠ 801**[1]	$4,000
☐ **Blue Advantage Silver HMO℠ Standard**[1]	$6,000
☐ **Blue Advantage Gold HMO℠ 206**[1]	$550
☐ **Blue Advantage Gold HMO℠ 207**	$0
☐ **Blue Advantage Gold HMO℠ 603**[1]	$1,000
☐ **Blue Advantage Gold HMO℠ Standard**[1]	$2,000

PLAN SELECTION
☐ **Blue Advan**
☐ **Blue Advan**
☐ **Blue Advan**
☐ **Blue Advan Standard**[1]
☐ **Blue Advan**
☐ **Blue Advan**
☐ **Blue Advan**
☐ **Blue Advan Standard**[1]
☐ **Blue Advan**
☐ **Blue Advan**
☐ **Blue Advan Standard**[1]
☐ **MyBlue He**
☐ **MyBlue He**
☐ **MyBlue He**
☐ **MyBlue He**
☐ **MyBlue He**
☐ **MyBlue He**

☐ **MyBlue He**

"CATASTROPHIC" PLAN OPTION BELOW

Here's what that means.

This plan covers essential health benefits, but generally only after you pay the high amount. **You qualify for this plan only if:**

1) you are under age 30 before the plan year begins, **or**
2) you have a waiver from the Health Insurance Marketplace®.
Your Exemption Certificate Number is required to process your form. **Exemptio**

☐ **Blue Advantage Security HMO℠ 200**[1]

[1] All plans listed here except Blue Advantage Gold HMO 207 are Consumer Choice P
Blue Advantage Gold HMO 207, you must sign the Consumer Choice Disclosure or

Choose your dental plan.

Appli

The Affordable Care Act requires that we seek reasonable assurance from you that yo
coverage for pediatric dental services (for children). The ACA considers coverage for p
health benefit that every policy must provide, even if there is no one on the policy wh

Companies like BCBSTX offer this dental coverage for children through "Marketplac
plans are also known as Dental Qualified Health Plans or Dental QHPs.

- For more information about these dental plan options, g
- Dependents 19 to 26 are considered adults for dental co
- If you already have dental coverage with us, whatever you
  current dental coverage.

Please **SELECT ONLY ONE OF THE THREE OPTIONS:**

OPTION 1 — Covers ADULTS WITH OR WITHOUT CHILDREN (c

FOR ADULTS

OR

ADULTS WITH CHILDREN

BlueCare Dental℠
☐ BlueCare Dental 1A
☐ BlueCare Dental 1B
☐ BlueCare Dental 1C
☐ BlueCare Dental 1D

OPTION 2 — Covers ONLY CHILDREN, UP TO AGE 19 (choose
DO NOT CHOOSE if you chose a plan in option 1.

FOR CHILDREN ONLY

BlueCare Dental 4 Ki
☐ BlueCare Dental 4 Kids
☐ BlueCare Dental 4 Kids

OPTION 3 Choose this option only if you already have den

Check the box and sign here to tell us that you have what is known as a "Mark
Our records will show that you have the Pediatric Dental essential health bene

Note: Checking this option will NOT result in a change or cancellat

☐ **I/we already have coverage for pediatric dental essential health**

Signature (REQUIRED if selecting Option 3)

If you do not make a choice, you and each member on the policy will our Limited Dental QHP, so you will have the required pediatric dental be

BCBSTX may find that pediatric dental coverage must be included with case, you may owe an additional monthly payment for pediatric dental part of your first payment and will be included in your monthly bill.

Tell us how you will make your payments.

Please be sure to read the important billing rules on

- Your plan may be canceled if you don't make a payment.
- **A valid personal email address is REQUIRED for ele**
- **If billing emails sent to the email address provided removed from EFT and bills will be mailed via USPS**
- **If you are a current member paying your premium** Payment Information, even if there are no changes.

FIRST PAYMENT

You may make your **first payment** by EFT, check or money order. Choose one:

☐ EFT (First payment will be taken from your account immediately.) ☐ Check

TIP: Write the name of the Primary Applicant in the memo/ different from name of account owner. **NOTE:** Use of a bus compliance with Third Party Payment Rules on page 12.

MONTHLY PAYMENTS

You may make your **monthly payments** by electronic funds transfer (Auto Bill Pa Select your choice:

☐ EFT (Auto Bill Pay - valid email required) ☐ Bill by email (valid email required

PREMIUM PAYMENT INFORMATION (ALL fields required if payi

Please check one ☐ Checking account ☐ Savings account	**Name(s) on account**
Bank routing number (please verify)	**Account numb**
Email address	

AGREEMENT (See full Auto Bill Pay Terms of Use on page 12.)

I confirm I want BCBSTX and/or its designee to take out monthly premium paymer named above. Funds will be taken out on the last business day of the month befor usual business day (any M-F) of the month is a holiday or other nonbanking day, fu day. Withdrawals may be in the form of checks, share drafts or electronic debit en institution named here to honor the same payments from my account.

☐ **I have read and accept this agreement**

Account owner's signature	**Date**

Do not cancel any current coverage you may have until your new plan is effective.

Your first month's payment is due when you sign up. If you **your coverage will not be in effect until we receive yo**

Important billing rules.

Appli

AUTO BILL PAY TERMS OF USE (email address required)

**If you allow EFT, you understand and agree that BCBSTX and/or the compa
may take monthly payments from your checking or savings account in acc**

- By signing up for Auto Bill Pay you authorize us and our service providers to stor selected payment method on a monthly basis unless you take timely steps to ca charged to your selected payment method on the last day of the month precedi Auto Bill Pay. If that day occurs on a weekend day or Federal holiday, the draft wi prior. The amount you will be charged will be based on your premiums and othe you. You will be notified by email if the amount of your payment changes.
- If you would like to cancel Auto Bill Pay please log into your Blue Access for Mem Pay cancellations must be received no later than 3 days before the billing date. C effective the next month.
- If your statement shows transfers that you did not make, including those made b do not tell us within 60 days after the statement was sent to you, you may not ge if we can prove that we could have stopped someone from taking the money if y as a long trip or a hospital stay) kept you from telling us, we will extend the time
- If you have told us in advance to make regular payments out of your account, yo Here's how:
  - Call us at the phone number found on the back of your member ID card or lc receive your request 3 business days or more before the payment is schedul
  - If these regular payments may vary in amount, we will tell you, 10 days before much it will be.
  - If you order us to stop one of these payments 3 business days or more befor so, we will be liable for your losses or damages.
- We may at any time and without notice amend these Auto Bill Pay Terms of Use. of Use. Your continued use of the Auto Bill Pay function after any such amendme change(s). We may discontinue Auto Bill Pay functionality for any reason and wit or conditions are modified.

THIRD PARTY PAYMENT RULES

BCBSTX follows the premium payment process established by the Affordab federal requirements.

1. BCBSTX accepts premium payments from the following third-party entities on b
   a. A Ryan White HIV/AIDS Program under title XXVI of the Public Health Service A

a. A Ryan White HIV/AIDS Program under title XXVI of the Public Health Service A

b. An Indian tribe, tribal organization or urban Indian organization; and

c. A local, state, or federal government program, including a grantee directed by its behalf.

2. BCBSTX may accept premium payments on behalf of enrollees from private, not-

a. For the entire coverage period of the enrollee's policy;

b. Based solely on the financial status of the enrollees;

c. Regardless of t

d. Regardless of t

3. BCBSTX may accept premium payments on behalf of enrollees from a Trust, Pow

4. BCBSTX will not construe payments from an employer as impermissible third-pa not create an Employee Retirement Income Security Act (also known as ERISA) g

a. The employer facilitates premium payment collection through payroll deducti the employer is not paying any part of the premium either directly or through

b. The employee is participating in an Individual Coverage Health Reimbursemer Employer Health Reimbursement Arrangement (QSEHRA) offered by their emp

5. BCBSTX will accept payments on behalf of an enrollee directly from an employer party payment coordination service, when such payments are made using allow

Tell us about other coverage.

Appli

COVERAGE YOU ARE REPLACING

Will this plan replace health coverage for 2026 you already have? **If yes, list all co terminate and replace with a plan from BCBSTX and read KNOW YOUR RIG**

COVERED PERSON(S)	NAME OF INSURANCE COMPANY	

KNOW YOUR RIGHTS WHEN YOU REPLACE COVERAGE

If you chose "Yes" above, BCBSTX may NOT automatically cancel your old policy. Th your current accident and health plan and replace it with a plan from BCBSTX. For should know how this decision may affect the coverage available to you in a new p

1. You may want to ask the company that offers the plan you are replacing about y agent. This is your right. It is in your best interest. You should be sure you unde replace the coverage you have now.
2. If you still wish to cancel your present plan and replace it with new coverage, be questions on this Application about any person applying for coverage. If you lea may have a legal basis to deny any future claims and to refund your premium as force. Before you sign the completed Application, re-read it carefully to be sure t

OTHER COVERAGE YOU OR YOUR DEPENDENT(S) MAY HAVE

Does any person applying for coverage currently have, or did they previously have

- Coverage with BCBSTX?
- Health coverage with any other insurance company?
- Coverage under a tax-supported or government program, including Medicare?

If yes, please provide details below:

Applicant Name	**Name on Other Policy** (if differe
Applicant Name	**Name on Other Policy** (if differe

Proxy Statement

Proxy Statement (OPTIONAL)

By purchasing a BCBSTX health plan, I become a member of Health Care Service Co
By signing this Proxy Statement, I ask the Board of Directors of HCSC to act on my b
understand that:

- This permission will apply to any company that replaces HCSC.
- The Board of Directors may appoint someone to vote for me.

The annual meeting of members is scheduled to take place each year in the corpor
Chicago, IL 60601) on the last Tuesday of October at 12:30 p.m. Special meetings of
any special meeting will be given within 30 to 60 days before the meeting.

My assignment of my member vote to the Board of Directors will be in effect:

- Until or if I cancel it in writing at least 20 days before any meeting of members, c
- Unless I attend and vote in person at any meeting of members

Primary Applicant's (your) proxy signature: **NOTE:** Whether you sign for proxy or not, you must sign on page 16 to complete this Application.
Print your name as you signed it:

Consumer Choice Disclosure

Appli

TEXAS DEPARTMENT OF INSURANCE REQUIRED DISCLOSURE N CHOICE HEALTH BENEFIT PLANS ISSUED IN TEXAS

Under Texas law, HMOs are permitted to market "Consumer Choice" plans, which c that are in Texas health plans known as state-mandated plans. HMOs are required showing they have been given this notice.

I have been informed that the consumer choice plan I am being offered doesn't incl Texas health plans known as state-mandated plans. This plan does include all healt

To see all benefits offered by this plan, go to the plan's "Summary of Benefits and C

BENEFIT/COVERAGE:	THIS PLAN:
Deductible The amount you pay for care before the plan begins to share the cost.	Has a deductible.
Out-of-Pocket Costs The amount you pay when you receive covered services, up to a calendar year maximum.	Includes out-of-pocket costs that meet federal requirements but may sometimes be more than in a state-mandated plan.
Habilitative and Rehabilitative Care Care that helps you improve skills for daily living.	Includes a limit on the number of visits per year for speech therapy, occupational therapy, physical therapy and chiropractic care. Limits do not apply for the treatment of acquired brain injury and autism spectrum disorder.
Home Health Services	Includes a limit for home health services.

If you want a plan with all required benefits:

We also offer a state-mandated plan[1] that includes all required benefits. This plan allow you to get help with premiums and out-of-pocket costs. To learn more about **bcbstx.com/shop-plans-and-products**.

By signing this form, you acknowledge the following:

I understand the consumer choice plan I am applying for does not provide the sam
health plans (state-mandated plans). I understand if my health changes and this pl
won't be able to get a new plan until the next open enrollment period. I understan
choice plans from the Texas Department of Insurance's website, https://www.tdi.te
by calling the Consumer Help Line at 800-252-3439.

Don’t sign this document if you don't und
No firme este documento si no lo com

Applicant’s Signature	**Print Applicant’s Name**
Address	**City**

Note: The HMO issuing the plan must give you a copy of this statement upon requ

[1] Blue Advantage Gold HMO 207 is the state-mandated plan.
[2] Talk to your independent, authorized agent or call 800-531-4456 for help.
[3] Para recibir ayuda, comuníquese con el agente independiente autorizado o llame

Please read and sign on next page.

BY COMPLETING AND SIGNING THIS FORM, I UNDERSTAND AN

- This Application is not coverage. Coverage will not begin until (1) the effective dat payment is made.[1]
- If I use an agent, they cannot accept risks or change the policies or rules of BCBS
- If an agent helps me purchase a new or renew a health plan, BCBSTX may pay the per month. My agents may also get bonus and marketing payments. These payme month for my plan.
- If any person knowingly submits a false claim for payment of a loss or benefit or Application, coverage may be rescinded. This includes false claims or facts abou cancels the coverage back to the first day it became effective. I will be given at le coverage or that of my dependents is rescinded.
- My monthly premium will be calculated using factors approved by the state's de state and federal laws and regulations. Rates are calculated based on age, tobac factors are also used to calculate premiums for any dependents covered on my
- I authorize any of the following people or organizations to share my health infor representative:
    - o Health professionals, hospitals, or clinics
    - o Other health or health-related facilities
    - o Government agencies
    - o Pharmacy benefit managers, clearinghouses, or retail stores
    - o Any other persons or firms required by law
    - › This information may include:
        - o Copies of records about advice, care or treatment that were given to me a
        - o Information about the prescription and use of drugs or alcohol
        - o Information about mental illness
    - › BCBSTX may review and research its own records for information.
    - › BCBSTX will share collected information only as needed with medical entities
    - › Information shared with my authorization may be re-shared by BCBSTX as al required, the person or agency getting the information will be responsible fo
    - › This authorization is valid for two years from today, or until I cancel coverage
        - o I have the right to cancel the authorization at any time, in writing, by conta
        - o I or anyone I authorize to represent me will receive a copy of this authoriz

- For anyone I authorize to represent me will receive a copy of this authoriz
  - Any cancellation will not affect the activities of BCBSTX before the date su
- I present any statements and answers on this Application as FACTS. To the best
  complete. These facts are the basis of my Application.
- The Application will become a part of the contract between BCBSTX and me.
- My agent (if I have one) and I confirm that I have read and understood the Applicati
- This individual or family plan is meant to be paid as my personal expense.
- Only I or a family member, or an allowed third party as outlined in the Applicatio
- BCBSTX does not accept payments directly from third parties except from those
- If these rules are broken, any payments made by a third party will not be credite
  payments may not be refunded to me. This may result in the cancellation of my

WARNING: ANY PERSON WHO KNOWINGLY, AND WITH INTENT TO INJURE, DEFRA
CLAIM FOR THE PROCEEDS OF A HEALTH PLAN CONTAINING ANY FALSE, INCOMPL
FOUND GUILTY OF A FELONY IN A COURT OF LAW.

[1] Some exceptions apply during a Special Enrollment Period. Check with your agent

Did you work with an agent?

Appli

AGENTS, COMPLETE THIS SECTION (IF APPLICABLE)

I certify that:

- I provided the Application to the Applicant(s) for completion, or I personally asked th
- I provided written material to explain the benefits to the Applicant(s). This inclu and any special details about their coverage.
- I have reviewed the required plan document(s) with the Applicant. This includes

Agent's Signature	**Agent's Printed Name**
Agent ID	**Agent's Phone**
Agent's Email	

Please read and sign below. (REC

YOUR SIGNATURE MAKES THIS A CONTRACT IF/WHEN FULLY PR

Primary Applicant's Printed Name AND Signature
Parent or Legal Guardian of a Minor Child Printed Name AND Signature (if chil
If this authorization is signed by a personal representative on behalf of an minor child), complete the following:
Personal Representative's Printed Name AND Signature

Send us your Application.

TO MAKE SURE YOUR FORM IS PROCESSED AS QUICKLY AS POSS

TO MAKE SURE YOUR FORM IS PROCESSED AS QUICKLY AS POSS

- Sign your form.
- Send **ALL PAGES** of this form.
  - **INCLUDE EVEN BLANK PAGES**.
- If you are working with an agent, please include your agent's information above.
- Please
- If you listed a sign

PLEASE SUBMIT THIS FORM BY:

MAIL	Blue Cross and Blue Shield of Texas, Attn: Individual Enrollment, PO Box 6
FAX	**800-279-7419**

Questions? If you have any questions, please call your agent or cal
Visit **discoverbcbstx.com** for frequently asked questions about m