

Last Name:

Social Security Number: 462 - 59 - 9466 | H Group #       **SECTION 6 — PREVIOUS COVERAGE INFORMATION**

DO NOT COMPLETE IF APPLYING FOR HMO OR IN-HOSPITAL INDEMNITY COVERAGE

In order to receive credit for pre-existing condition waiting periods, you must provide information about the last 12 months of coverage (18 months if new/current coverage is self-funded) for you and any dependents listed. If you have a certificate of prior coverage, please attach a copy to this enrollment application. (If more than one plan was in effect, or if information is different for dependents, attach additional pages.) If Medicare, please complete the Medicare Coverage Information in Section 8.

**List names of every individual covered:**

Name of Primary Enrollee <u>Ross Andrews</u>	Date of Birth <u>06/02/1982</u>	<input checked="" type="checkbox"/> Male <input type="checkbox"/> Female	Relationship to Applicant <input checked="" type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent	Group or Policy No. <u>550179</u>	ID Number <u>007658679</u>
Employer's Name: <u>Westlake Products</u>		Employment Date <u>07/15/2009</u> Effective Date <u>11/10/2009</u> Will Coverage be Continued? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If No, Expected Cancel Date <u>01/18/2010</u>		Type of Coverage <input checked="" type="checkbox"/> Health <input checked="" type="checkbox"/> Dental	Type of Policy <input checked="" type="checkbox"/> Self <input type="checkbox"/> Family <input type="checkbox"/> Employee/Spouse <input type="checkbox"/> Employee/Child
Name and address of other insurance company, TPA, HMO: <u>Humana</u>					

**SECTION 7 — OTHER COVERAGE INFORMATION**

Complete this section only if you or any of your dependents have other health and / or dental coverage **that will not be cancelled** when the coverage under this application becomes effective. **List names of each individual covered:**

Type of Coverage <input type="checkbox"/> Health <input type="checkbox"/> Dental	Group Coverage <input type="checkbox"/> Yes <input type="checkbox"/> No	Name and Address of Other Health Care Company			
Name of Policyholder	Date of Birth / /	<input type="checkbox"/> Male <input type="checkbox"/> Female	Relationship to Applicant <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent	Type of Policy <input type="checkbox"/> Self <input type="checkbox"/> Two Person <input type="checkbox"/> Family	
ID Number	Employment Date	Effective Date of Coverage	Group or Policy Number	Employer's Name	

**SECTION 8 — MEDICARE COVERAGE INFORMATION**

<b>Name of person covered:</b>	<b>Medicare HIC# (from ID card):</b>
<input type="checkbox"/> Medicare Part A (hospital) Start Date: _____ End Date: _____ Month/Day/Year Month/Day/Year	<input type="checkbox"/> Medicare Part B (medical) Start Date: _____ End Date: _____ Month/Day/Year Month/Day/Year
<input type="checkbox"/> Medicare Part D (prescription drugs) Start Date: _____ End Date: _____ Month/Day/Year Month/Day/Year	If BCBSTX is not the Medicare Part D carrier, please provide name and address of the carrier: Name: _____ Address: _____ City State
Check reason for Medicare eligibility: <input type="checkbox"/> Entitled age <input type="checkbox"/> Entitled disability <input type="checkbox"/> End-stage renal disease <input type="checkbox"/> Disability and current renal disease	
<b>Name of person covered:</b>	<b>Medicare HIC# (from ID card):</b>
<input type="checkbox"/> Medicare Part A (hospital) Start Date: _____ End Date: _____ Month/Day/Year Month/Day/Year	<input type="checkbox"/> Medicare Part B (medical) Start Date: _____ End Date: _____ Month/Day/Year Month/Day/Year
<input type="checkbox"/> Medicare Part D (prescription drugs) Start Date: _____ End Date: _____ Month/Day/Year Month/Day/Year	If BCBSTX is not the Medicare Part D carrier, please provide name and address of the carrier: Name: _____ Address: _____ City State
Check reason for Medicare eligibility: <input type="checkbox"/> Entitled age <input type="checkbox"/> Entitled disability <input type="checkbox"/> End-stage renal disease <input type="checkbox"/> Disability and current renal disease	

**SECTION 9 — DISABLED DEPENDENT**

Name of disabled dependent	Nature of disability
Has disability been diagnosed as permanent? <input type="checkbox"/> Yes <input type="checkbox"/> No If temporary, how long is dependent expected to remain disabled? _____	
Is dependent unable to work due to the disability? <input type="checkbox"/> Yes <input type="checkbox"/> No If disabled child is over the dependent age limit of your employer's plan, please attach a completed Dependent Child's Statement of Disability form.	

**SECTION 10 — DECLINATION OF HEALTH COVERAGE**

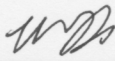
This is to certify the available coverage has been explained to me, I have been given the opportunity to apply for the coverage offered to me and my eligible dependents and have voluntarily elected to decline the coverage as indicated below. If I desire to apply for coverage at a later date, I understand there may be a delay in the effective date of the coverage as well as a pre-existing condition waiting period.

Employee	Reason for declining: <input type="checkbox"/> Other Group Coverage <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> Other, explain: _____
Spouse	Reason for declining: <input type="checkbox"/> Other Group Coverage <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> Other, explain: _____
Child(ren)	Reason for declining: <input type="checkbox"/> Other Group Coverage <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> Other, explain: _____

**SECTION 11 — COVERAGE CONDITIONS**

- I am an employee of the Employer named in this Enrollment Application. I am eligible to participate in the coverage(s) afforded by my Employer's plan, which is either underwritten or administered by Blue Cross and Blue Shield of Texas (BCBSTX) or Fort Dearborn Life Insurance Company (FDL). On behalf of myself and any dependents listed on this Enrollment Application, I apply for those coverage(s) for which I am eligible. I state that the information given on this Enrollment Application is true and correct. I understand and agree that any incorrect statements material to the risk and knowingly made by me will invalidate my coverage(s).
- Only those coverage(s) and amounts for which I am eligible will be available to me. I understand that if this Enrollment Application is accepted, the coverage(s) will become effective in accordance with the provisions of the Contract(s)/Plan(s).
- I understand that the Health coverage for which I am applying may have a pre-existing condition exclusion waiting period.
- I agree that my Employer acts as my agent. I authorize necessary payroll deduction by my Employer, if any, to cover the cost of my coverage(s).
- I understand that my participation in the coverage(s) is subject to any future amendment. I also understand that all notices given to my Employer are binding upon me.

Applicant's Signature

Date 23 Jan 2010