

TMAIT Enrollment Application/Change Form

PLEASE READ THE INSTRUCTIONS ON THE INSIDE THOROUGHLY BEFORE COMPLETING THIS ENROLLMENT APPLICATION/CHANGE FORM



**Texas Medical Association
Insurance Trust**

Created and endorsed by the Texas Medical Association

ENROLLMENT APPLICATION /CHANGE FORM INSTRUCTIONS

PLEASE READ THOROUGHLY BEFORE COMPLETING ENROLLMENT APPLICATION / CHANGE FORM

Use a black or blue ball point pen only. Print neatly. Do not abbreviate.

SECTION 1

Check all the boxes that apply to indicate if you are a new member or if you are requesting a change to your coverage. Indicate the event and date, if applicable. Complete the additional sections that correspond to your selection.

New Member: Complete Sections 1, 2, 3, 4, 5, 6, 7, 8, 9, 10 and 11 where applicable.

Add Dependent: Complete Sections 1, 2, 3, 4, 5, 6, 7, 8, 9, 10 and 11 where applicable. If adding dependent by court order, please attach a copy of court order or decree.

Change Address / Name: Complete Sections 1, 2 and 11.

Cancel Member or Dependent: Complete Sections 1, 2, 4, and 11. In Section 4 include name, social security number, and date of birth of individual(s) disenrolling.

SECTIONS 2 & 3

Complete all areas that apply to you.

SECTION 4

Complete all areas that are applicable to you and each dependent, if applying for dependent coverage.

IMPORTANT NOTICE — DEPENDENT CHILD ELIGIBILITY

- 1) A child of the Member's child can be listed as a dependent if IRS guidelines are met at the time of application.
- 2) A court-ordered dependent child is eligible. A copy of the court order or decree must be submitted.
- 3a) A child includes (1) a natural child, (2) a step-child, (3) a court ordered dependent child, (4) an adopted child, (5) a child involved in a suit for adoption, (6) a child of any age who is medically certified as disabled, (7) a child of the Member's child, or (8) a foster child.
- 3b) A child not identified in (1) through (7) above can be listed if the child's primary residence is the Member's household, to whom the Member is legal guardian or related by blood or marriage, and who is dependent upon the Member for more than one-half of his support as defined by the IRS of the United States.
- 4) If adding a disabled child who exceeds the age limit in the TMAIT contract and meets IRS support guidelines, complete Section 6, Disabled Dependent.

SECTION 5

Complete this section if you or any of your dependents are covered by Medicare.

SECTION 6

Complete this section if you are applying for coverage for a disabled dependent over the age limit. A disabled dependent must be certified by Medical Underwriting and a completed Dependent Child's Statement of Disability form must be submitted with this enrollment application.

SECTION 7

Complete this health statement section, unless applying for In-Hospital Indemnity, only.

SECTION 8

Complete additional information to supplement health statement section.

SECTION 9

Complete this section, unless you are applying for In-Hospital Indemnity, only.

SECTION 10

Complete this section if you or any dependent have other health care coverage through an employer.

SECTION 11

Sign your name, initial the health authorizations and date the enrollment application if you agree to the conditions set forth in this section. Your enrollment application should be submitted to TMAIT. The application will then be forwarded to BCBSTX.

If you have any questions, please contact your Marketing Service Representative.

Group # 84066 (Plan Options 1-16)

Section # Dept #

Group # 84905 (Plan Options 17-20)

Section # Dept #

Social Security Number

Texas Medical Association
Insurance Trust
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BCBSTX Subscriber Identification (ID) Number _____

SECTION 1 — ENROLLMENT EVENTS PLEASE CHECK ALL THAT APPLY

New Member **Add Dependent**
Event: Marriage Birth or Adoption
 Court Order (See Instructions)
 Suit for Adoption
 Other (See Instructions) Explain:

Indicate Event Date: ____ / ____ / ____

Add Coverage: Health

Cancel Member **Cancel Dependent**
List names of those canceling in section 4 below
Event: Divorce Death
 Participation in TMAIT terminates

Indicate Event Date: ____ / ____ / ____

Cancel Coverage: Health
 Change Address/Name

Are you applying as a result of:
 Marriage Birth or Adoption
 Suit for Adoption Court Order
 Loss of Coverage (provide Certification of Coverage)
 Other. Explain:

Indicate Event Date: ____ / ____ / ____

SECTION 2 — PLEASE TELL US ABOUT YOURSELF

Last Name		First	Middle	Height	Weight	Birth Date (Mo Day Yr)	Social Security Number	
Sex	Medical Specialty			BCBSTX Subscriber ID Number		Work Phone No.		
<input type="checkbox"/> Male <input type="checkbox"/> Female						()		
Home Address — No. and Street Address			City	State	Zip	Home Phone No.		
						()		
Billing Address — No. and Street Address			City	State	Zip			

SECTION 3A — SELECT YOUR COVERAGE — GROUP NO. 84066

Members (select one) Member Only Member/Spouse Member/Child(ren) Family

- PPO Option 1
- PPO Option 2
- PPO Option 3
- Traditional Medical Benefits Option 4
- Traditional Medical Benefits Option 5
- Traditional Medical Benefits Option 6
- Traditional Medical Benefits Option 7
- Traditional Medical Benefits Option 7A
- Traditional Medical Benefits Option 8
- Traditional Medical Benefits Option 9
- Traditional Medical Benefits Option 10
- Traditional Medical Benefits Option 11
- Traditional Medical Benefits Option 12
- Traditional Medical Benefits Option 13
- Traditional Medical Benefits Option 14
- Traditional Medical Benefits Option 15
- Traditional Medical Benefits Option 16

SECTION 3B — ADDITIONAL PLAN OPTIONS — GROUP NO. 84905

You may choose one of the Plan Options below in addition to your selection (above) or as your only Plan Option selection.

Members (select one) Member Only Member/Spouse Member/Child(ren) Family

- In-Hospital Indemnity Plan Option 17 [\$100 Daily Allowance]
- In-Hospital Indemnity Plan Option 18 [\$150 Daily Allowance]
- In-Hospital Indemnity Plan Option 19 [\$200 Daily Allowance]
- In-Hospital Indemnity Plan Option 20 [\$250 Daily Allowance]

SECTION 4 — COVERAGE OPTIONS COMPLETE IF APPLYING FOR DEPENDENT COVERAGE

Member's Name

Dependent's Name Husband Wife

Dependent's Social Security No.	DOB (Mo Day Yr)	Height	Weight	Home Address, if different — No. and Street Name	City	State	Zip
—							

Dependent's Name Son Daughter

Dependent's Social Security No.	DOB (Mo Day Yr)	Height	Weight	Home Address, if different — No. and Street Name	City	State	Zip
—							

Dependent's Name Son Daughter

Dependent's Social Security No.	DOB (Mo Day Yr)	Height	Weight	Home Address, if different — No. and Street Name	City	State	Zip
—							

Dependent's Name Son Daughter

Dependent's Social Security No.	DOB (Mo Day Yr)	Height	Weight	Home Address, if different — No. and Street Name	City	State	Zip
—							

SECTION 5 — MEDICARE COVERAGE INFORMATION

Name of person covered:	<input type="checkbox"/> Medicare A (Hospital) Effective Date: ___/___/___	Medicare No. (From Medicare Card)
	<input type="checkbox"/> Medicare B (Medical) Effective Date: ___/___/___	
Name of person covered:	<input type="checkbox"/> Medicare A (Hospital) Effective Date: ___/___/___	Medicare No. (From Medicare Card)
	<input type="checkbox"/> Medicare B (Medical) Effective Date: ___/___/___	

Please check the reason for Medicare Eligibility Entitled Age Entitled Disability End-Stage Renal Disease Disability and Current Renal Disease

SECTION 6 — DISABLED DEPENDENT

ATTACH A STATEMENT OF DEPENDENT CHILD'S STATEMENT OF DISABILITY FORM

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	

SECTION 7 — HEALTH STATEMENT

DO NOT COMPLETE IF APPLYING ONLY FOR THE ADDITIONAL PLAN OPTIONS IN SECTION 3B (IN-HOSPITAL INDEMNITY)

Please provide information regarding the last doctor's visit and/or physical examination for ALL family members you wish to cover in No. 3) in Section 8.

- | | Yes | No |
|--|--------------------------|--------------------------|
| 1. Is any person applying or residing in the household currently pregnant? If "Yes," please explain in No. 3) in Section 8. | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Does any person applying for coverage take any prescription medication or has any person done so within the last two years?
If Yes, explain in No. 2) in Section 8. | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Has any person applying for coverage had or been treated for any abnormal test results, laboratory, x-ray and/or recurring medical condition?
If Yes, please explain in No. 1) in Section 8. | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Has anyone applying for coverage ever been diagnosed as having or told by a medical doctor that he/she has AIDS, HIV, or ARC disorders? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Have you or any person applying for coverage ever been tested positive for antibodies for the AIDS virus? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Has any person applying been diagnosed by a member of the medical profession as having AIDS and/or has any proposed insured received treatment from a member of the medical profession for AIDS? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. To the best of your knowledge, has any person applying for coverage EVER HAD or is any such person now having symptoms, treatment, surgery or a diagnosis of any of the following conditions in A-P below? Check either "YES or "NO" to each part. If "Yes," circle the specific ailment(s) in the section below and enter the detailed information in No. 1) in Section 8. Any person applying for coverage may be asked to provide the results of a recent physical exam. | | |

<p>A Heart/Cardiovascular: high or low blood pressure, chest pain, congestive heart problems, heart attack, heart surgery (including angioplasty/bypass, valve or any other heart/vessel surgery), mitral valve prolapse, irregular heart beat, pacemaker, congenital heart disorders, murmur, rheumatic fever, elevated cholesterolYes <input type="checkbox"/> No <input type="checkbox"/></p> <p>B Circulatory: varicose veins, phlebitis, carotid artery disorder, blood clot, stroke, peripheral vascular disease, enlarged lymph nodes or any circulatory disorderYes <input type="checkbox"/> No <input type="checkbox"/></p> <p>C Digestive: colon/intestinal disorder (polyps, colitis, chronic diarrhea), esophagus, stomach, ulcers, hernia, gallbladder, pancreatitis or any testing/evaluation for any digestive disorderYes <input type="checkbox"/> No <input type="checkbox"/></p> <p>D Liver Disease/Disorder: hepatitis (give type, date and treatment), cirrhosis, blood transfusion, abnormal liver studiesYes <input type="checkbox"/> No <input type="checkbox"/></p> <p>E Mental/Emotional/Behavioral: alcohol/drug abuse or addiction, depression/anxiety, chemical imbalance, bipolar, hyperactivity/ADD, mental deficiency/retardation, anorexia, bulimia, counseling/ therapy or support groupsYes <input type="checkbox"/> No <input type="checkbox"/></p> <p>F Brain/Nervous System: epilepsy, convulsions, tremors, fainting, headaches, dizziness, paralysis, neuropathy, concussion, any loss of consciousness or other disease/dysfunction of the brain/nervous systemYes <input type="checkbox"/> No <input type="checkbox"/></p> <p>G Endocrine/Metabolic: diabetes, lupus, abnormal glucose level, thyroid, pituitary, adrenal or growth disorder, anemia or any other blood disorder (type/treatment/date), persistent/chronic fatigue, night sweats, 15 lbs or more weight loss in last 12 monthsYes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>H Lungs/Respiratory: asthma, bronchitis, pneumonia, emphysema, obstructive respiratory disorders, tuberculosis (history of or exposure to), chemical or asbestos exposure, shortness of breath, apnea/sleep disorder, use of any respiratory equipment or oxygen to assist with breathingYes <input type="checkbox"/> No <input type="checkbox"/></p> <p>I Cancer: Cancer, leukemia, Hodgkin's disease, Kaposi's sarcoma, melanomaYes <input type="checkbox"/> No <input type="checkbox"/></p> <p>J Tumors: Tumor, cyst or growth (benign/malignant) . . .Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>K Breast Disease/Disorder: any changes, lump(s), aspiration(s), biopsies or breast implants (provide type/ complications)Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>L Male/Female Disease/Disorder: kidney/bladder, uterus/tubes/ ovaries, prostate, stones, incontinence, infertility, endometriosis, genital warts, herpes or any other sexually transmitted diseaseYes <input type="checkbox"/> No <input type="checkbox"/></p> <p>M Musculoskeletal System: arthritis (type/joints affected), gout, polio, congenital disorder, back/neck/spine disorder, muscular disease/disorder, bone/joint, injury, fracture, hardware present, amputation or any surgical procedures. Provide Left ___Right ___if applicableYes <input type="checkbox"/> No <input type="checkbox"/></p> <p>N Eye/Ear Disease/Disorder: any impairment of sight, hearing or speech or any surgical proceduresYes <input type="checkbox"/> No <input type="checkbox"/></p> <p>O Any Other Disease, Disorder or Surgical Procedure?Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>P Has any PERSON been advised of future treatment, surgery, therapy, hospitalization, testing or evaluation?Yes <input type="checkbox"/> No <input type="checkbox"/></p>
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Last Name: _____ BCBSTX Subscriber ID Number: _____ Group # 84066 (Plan Options 1-16)

Social Security Number: _____ Group # 84905 (Plan Options 17-20)

SECTION 9 — PREVIOUS COVERAGE INFORMATION

COMPLETE ONLY IF APPLYING FOR COVERAGE OTHER THAN IN-HOSPITAL INDEMNITY

In order to receive credit for pre-existing condition waiting periods, you must provide information about the last 12 months of coverage 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 5. **List names of every individual covered:**

Name of Primary Member	Birth Date (Mo Day Yr)	<input type="checkbox"/> Male <input type="checkbox"/> Female	Relationship to Applicant <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent	Group or Policy No.	ID Number
Prior Coverage with:	Employment Date, if applicable ___/___/___	Effective Date ___/___/___	Type of Coverage <input type="checkbox"/> Health <input type="checkbox"/> Dental <input type="checkbox"/> Employer Sponsored <input type="checkbox"/> Individual Purchase	Type of Policy <input type="checkbox"/> Self <input type="checkbox"/> Employee/Spouse <input type="checkbox"/> Employee/Child <input type="checkbox"/> Family	
Name and address of other insurance company, TPA, HMO		Will Coverage be continued? <input type="checkbox"/> Yes <input type="checkbox"/> No If No, Expected Cancel Date ___/___/___			

SECTION 10 — OTHER COVERAGE INFORMATION

Are you or any member of your family listed above covered by any other health coverage? Yes No If yes, list names of every individual covered:

Type of Coverage <input type="checkbox"/> Health	Group Coverage <input type="checkbox"/> Yes <input type="checkbox"/> No	Name and Address of Other Health Care Company			
Name of Policyholder	Birth Date (Mo Day Yr)	<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 Coverage <input type="checkbox"/> Self <input type="checkbox"/> Two Person <input type="checkbox"/> Family	
ID Number	Effective Date of Coverage	Group or Policy Number	Employer's Name		

SECTION 11 — COVERAGE CONDITIONS

- I am a Member of the Texas Medical Association and a participant in the Texas Medical Association Insurance Trust or I am an Executive Director with County Medical Specialty Societies or State Medical Societies. I am eligible to participate in the coverage(s) afforded by the Texas Medical Association Insurance Trust, which is underwritten by Blue Cross and Blue Shield of Texas (BCBSTX). 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) 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).
- I understand that the health coverage I am applying for may be subject to a preexisting condition exclusion (not applicable if applying for In-Hospital Indemnity).
- I agree to pay to TMAIT the required premium as it becomes due. TMAIT, while not an agent of BCBSTX, will be responsible for collection of premiums from Members. I understand that all Notices given to TMAIT are binding upon me.
- I also agree that my participation in the coverage(s) is subject to any future amendments. I understand no agent can: (1) accept risks, or (2) modify documents, or (3) waive any right or requirements.
- Health Authorization:** I authorize any hospital, physician, provider, clinic or medical related facility, governmental agency, insurance carrier, group health plan or other entity to give BCBSTX or its authorized representative, upon request, any information concerning the health condition of any person listed on this Enrollment Application whenever such information is considered necessary by BCBSTX for the proper disposition of this Enrollment Application.

I understand that this authorization is voluntary and that my signature is required for BCBSTX to consider this Enrollment Application and to make a determination on whether to accept and issue the coverage applied for herein and that without my signed authorization no action will be taken on this Enrollment Application. I also understand that I may revoke this authorization at any time in writing and that such revocation will have no effect on any actions taken by BCBSTX prior to receipt of the revocation. I further understand the potential that any information disclosed pursuant to this authorization may be redisclosed and is no longer protected by the Federal privacy laws. A photographic copy of this authorization shall be as valid as the original. Yes No **Initial** _____

- I hereby give authorization to my Agent/Producer and TMAIT to inquire and discuss information contained in the Enrollment Application as well as the final disposition of my Enrollment Application.
 Yes No **Initial** _____ (If left blank or not initialed, "NO" is considered the answer)

Signatures: _____ Member _____ Date _____ Spouse (if to be insured) _____
Date _____ Dependent Child (if over 18) _____ Date _____

Monthly Electronic Funds Transfer Authorization

If you wish to use your checking account, enclose a blank voided check for that account. If you wish to use your credit union account, you must confirm that your bank permits electronic funds withdrawals. By my signature below I authorize the Texas Medical Association Insurance Trust to charge my bank account for the amount of my insurance contribution payment until such time as I provide written notice of cancellation, or insurance is terminated. *Please note: by enrolling for EFT all your insurance coverage provided by TMAIT will be billed via monthly EFT.*

Account Owner's Name: _____ Bank or Credit Union Name: _____ Type of Account: Checking Savings
Bank's Transit Routing Number (9 digits required): _____ Your Account Number: _____ Signature of Account Owner: _____

Agent's Certification: I certify that I sent the Enrollment Application to the Applicant(s) for completion or I personally asked the questions and recorded the answers as given. I further certify that I have no knowledge of any other medical information about the Applicant(s) not contained in this enrollment application and that written material explaining the benefits, exclusions and provisions of the Contract was sent to the Applicant(s). Do you have any knowledge or reason to believe that replacement of any existing coverage may be involved? Yes No If "Yes," explain in by attached notice.

Agent FAX # _____ Tax ID # _____ Agency Name (print) _____
Agent Address - Street _____ City _____ ZIP _____
Agent Name (print) _____ Agt. # _____ % _____ Signature _____ Phone _____ Date _____
Agent Name (print) _____ Agt. # _____ % _____ Signature _____ Phone _____ Date _____
TMAIT Signature (Optional) _____ Date _____

DO NOT WRITE IN SPACES BELOW

Approved <input type="checkbox"/>	Underwriter _____	The following named Applicant(s) shall not be included for coverage under this Contract: _____ _____ _____
Declined <input type="checkbox"/>	Decision Date _____	
Incomplete <input type="checkbox"/>	Effective Date _____	



Blue Cross and Blue Shield of Texas, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association.

Texas Medical Association Insurance Trust
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