BlueCross BlueShield of Texas*

Group Accounts Miscellaneous Change Form

Complete In Ink

GLH Group Life and Health Insurance Company*

Section 1

Group No.	Health/Life Subscriber No. if applicable				
Primary Insured Last Name	First	Middle			Sex ☐ Male ☐ Female
Home Address — No. and Street Name ☐ Check only if address has changed	City	State	ZIP		Home Telephone No. ( ) Work Telephone No. ( ) Cell Telephone No. ( )
E-mail Address					

Section 2 — Check Applicable Box(es)

☐ Change My Name To:	Check reason and show effective date ☐ Married ____/____/____ ☐ Divorced ____/____/____ ☐ Other ____/____/____

☐ Add Coverage Date: ____/____/____
☐ Cancel Coverage

Section 3 — Complete All Information for Each Dependent Being Added or Dropped

(1) A child of the member's child can be listed as a dependent, only if IRS guidelines are met.
(2) Stepchildren can be listed as dependents.
(3) A child can be listed if a participant receives a court order to cover that child. Your employer will supply a separate form for those dependents.
(4) When other than a natural or adopted child, or a court ordered dependent child, is listed as a dependent, they must meet IRS guidelines and the member's address must be their primary address.
(5) If adding a disabled child who exceeds the age limit in your Association's contract, complete the Over-age Dependent Information in Section 4.
(6) Add or drop dependent.

☐ Premium Plan ☐ Select Plan

List full name of all dependents to be covered	Social Security Number	Date of Birth Mo Day Yr	Height	Weight	Select Dependent Coverage Health	Dental
☐ Husband ☐ Wife	– –				☐ Yes ☐ No	☐ Yes ☐ No
Complete ONLY if different from employee's address	Number and Street Name	City	State		ZIP	
List full name of all dependents to be covered ☐ Son ☐ Daughter	Social Security Number – –	Date of Birth Mo Day Yr	Height	Weight	Select Dependent Coverage Health ☐ Yes ☐ No	Dental ☐ Yes ☐ No
Complete ONLY if different from employee's address	Number and Street Name	City	State		ZIP	
List full name of all dependents to be covered ☐ Son ☐ Daughter	Social Security Number – –	Date of Birth Mo Day Yr	Height	Weight	Select Dependent Coverage Health ☐ Yes ☐ No	Dental ☐ Yes ☐ No
Complete ONLY if different from employee's address	Number and Street Name	City	State		ZIP	
List full name of all dependents to be covered ☐ Son ☐ Daughter	Social Security Number – –	Date of Birth Mo Day Yr	Height	Weight	Select Dependent Coverage Health ☐ Yes ☐ No	Dental ☐ Yes ☐ No
Complete ONLY if different from employee's address	Number and Street Name	City	State		ZIP	

(Complete reverse side)

Section 4 — Over-age Dependent Information

Name of disabled dependent: _____

Nature of disability: _____

Has disability been diagnosed as permanent? ☐ Yes ☐ No If temporary, how long is child expected to remain disabled? _____

Is child unable to work due to the disability? ☐ Yes ☐ No

Section 5 - Health Statement

If you answered yes to any of these questions, please explain in the space provided.

		Yes	No
1.	Does any person applying for coverage take any prescription medication or has any person done so within the last two years? If yes, explain below.	☐	☐
2.	Has any person applying for coverage ever been refused, postponed, limited or charged extra premium for health or life insurance by any company? If yes, explain below.	☐	☐
3.	The following questions must be answered regarding the member and all dependents listed on this application. Each question must be answered truthfully. Check either "yes" or "no" to each question and **CIRCLE** the specific ailment; provide related information in the boxed space below.		
	Has anyone ever been advised that they had, or have been treated for any disease or disorder related to the following?		
CIRCLE CONDITION	a. Alcohol/drug abuse or treatment, nervous/mental/psychological disorders, hyperactivity/ADD, or eating disorder	☐	☐
	b. Diabetes, hepatitis, digestive disorder, intestine, stomach, liver, thyroid, pancreas, adrenal glands	☐	☐
	c. Blood pressure, heart disorder, stroke, chest pain, murmur, circulatory disorder, varicose veins, blood disorder, anemia	☐	☐
	d. Kidney/bladder, breast disorders, breast implants, prostate, male/female disorders, any sexually transmitted disease; Any person currently pregnant? (Indicate due date and any complications below.)	☐	☐
	e. Arthritis, polio, back/neck, muscle, bone, joint, injury, deformity	☐	☐
	f. Cancer, leukemia, Hodgkin's disease, kaposi's sarcoma, melanoma, cyst/tumor/growth (benign/malignant)	☐	☐
	g. Brain, epilepsy, convulsions, paralysis; impairments of sight/hearing, cataracts	☐	☐
	h. Immune system disorder, including acquired immune deficiency syndrome (AIDS), AIDS-related complex (ARC), tested positive for HIV	☐	☐
	i. Persistent fatigue, night sweats, 15 lb. weight loss or more in last 12 months	☐	☐
4.	Is there any other physical disorder or deformity or has anyone been advised of future treatment/hospitalization?	☐	☐

Explanation: _____

_____

_____

_____

_____

Complete this section only if you are on blood pressure medication or have been diagnosed with high blood pressure.

Blood Pressure Information: Date first diagnosed _____ /_____/_____ Provide two blood pressure readings for:

Last 12 months: Mo Yr ____/____ Reading ____/____

Current Reading: Mo Yr ____/____ Reading ____/____

If treatment has been discontinued, provide date _____/_____/_____. If there have been any EKG, or blood chemistry abnormalities or other complications, give details.

Name	Details of Diseases, Condition, Type Surgery or Treatment	Date First Treated		Hospitalized		Surgery		Current Medications/Any Remaining Problems	Names and Addresses of Physicians and Hospitals
		Mo	Yr	Mo	Yr	Mo	Yr		

As a supplement to my previous Application, I request the change(s) in coverage as indicated above. I understand that any incorrect statements material to the risk and knowlingly made by me in this supplement to my Application may invalidate the coverage of those for whom I am applying.

_____ **X** _____ **Home Phone Number** ( ) _____

Date **Signature**

Form No. TSCRA-Ee. Ap. -3

*Independent Licensees of the Blue Cross and Blue Shield Association