BlueCross BlueShield of Texas

North East ISD Notice of Enrollment or Change in Health Coverage

PLEASE PRINT CLEARLY

COBRA

1

☐ New Enrollment	☐ Change in Coverage	Notification Date To BCBS	Approval	Effective Date **JANUARY 1, 2027**

Date of Birth	Last Name	First Name	Middle	**Last 4 of Social Security Number:**

Home Address – No. and Street Name	City	State	Zip Code	Telephone #	Sex ☐ Male ☐ Female

2

☐ Cancel Coverage

☐ Change Health Selection from ______________________________ to ________________________________

☐ Add Dependent(s)* ☐ Drop Dependent(s)* ***Select one coverage category below and (if applicable) list eligible dependent(s)***

☐ **COBRA Participant Only**	☐ **COBRA Participant + Spouse**	☐ **COBRA Participant + Child(ren)**	☐ **COBRA Participant + Family**

SELECT ONE COVERAGE OPTION

☐ Blue Essentials (HMO) (Group# 432451)	☐ BlueChoice High Option (PPO) (Group# 093748)	☐ BlueEdge High Deductible Health Plan (HDHP) (Group# 190965)

3

Dependent Information: Full Name:		**Relationship:** ☐ Spouse ☐ Child	**Sex** ☐ Male ☐ Female
Dependent's SSN	**Date of Birth**	Home Address *(If different):* No. and Street Name City State Zip Code	
Dependent Information: Full Name:		**Relationship:** ☐ Spouse ☐ Child	**Sex** ☐ Male ☐ Female
Dependent's SSN	**Date of Birth**	Home Address *(If different):* No. and Street Name City State Zip Code	
Dependent Information: Full Name:		**Relationship:** ☐ Spouse ☐ Child	**Sex** ☐ Male ☐ Female
Dependent's SSN	**Date of Birth**	Home Address *(If different):* No. and Street Name City State Zip Code	
Dependent Information: Full Name:		**Relationship:** ☐ Spouse ☐ Child	**Sex** ☐ Male ☐ Female
Dependent's SSN	**Date of Birth**	Home Address *(If different):* No. and Street Name City State Zip Code	

I am an employee of North East Independent School District. I am eligible to participate in the coverage(s) afforded by my Employee Benefit Plan, which is either underwritten or administered by Blue Cross and Blue Shield of Texas, Inc. (BCBSTX) On behalf of myself and any dependents listed on this Application, I apply for those coverage(s) for which I am eligible. I state that the information given on my 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 Application is accepted, the coverage(s) will become effective in accordance with the provisions of the coverage(s).

I authorize my Employer to deduct from my wages or salary, any of the contributions as they become due. I agree that my Employer acts as my agent. All notices given to it 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.

I authorize any hospital, physician, dentist, provider, insurance carrier, or other entity to give the Companies, upon request, any information covering the health condition of any person included under the coverage(s) whenever the information is considered necessary by the Companies for proper disposition of the Application or of a claim submitted for payment.

Applicant's Signature ____ **Date**______________________

Form No. NEISD-EE-APP-2026