

Enrollment Form

Please print out and sign form after completing.
All eligible employees **MUST** complete this form.



TEXAS AGRICULTURAL COOPERATIVE TRUST

EMPLOYEE INFORMATION					
Group Number []	Employer Name []	Division/Location []	Date of Hire/Full Time [] / [] / []	Effective Date [] / [] / []	
Social Security Number [] - [] - []	Last Name []	First Name []	M.I. []	Date of Birth [] / [] / []	
Mailing Address: Street []		City []	State []	Zip []	Gender <input type="radio"/> Male <input type="radio"/> Female
Home Phone [] - [] - []	Work Phone [] - [] - []	Annual Salary \$ []	Hours Worked per Week []	Marital Status <input type="radio"/> Single <input type="radio"/> Divorced <input type="radio"/> Widowed <input type="radio"/> Married <input type="radio"/> Legally Separated	Date of Marriage [] / [] / []

Life / AD&D Election <input type="checkbox"/> Employee Life/AD&D <input type="checkbox"/> Dependent Life	Health Plan Election <input type="checkbox"/> Medical / RX / Vision: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child(ren)	If declining coverage <input type="checkbox"/> Other group coverage <input type="checkbox"/> Medicare/Medicaid <input type="checkbox"/> Other: []			
If COBRA enrollee... COBRA original effective date: [] / [] / [] Month paid up through: [] / [] / []	If Retiree enrollee... Date of retirement: [] / [] / [] Years of service: []	If Medicare Eligible... <input type="checkbox"/> Part A <input type="checkbox"/> Part B	Have you been enrolled in TACT before? <input type="radio"/> Yes <input type="radio"/> No		

Benefits provided may be subject to pre-existing conditions for the first twelve (12) months. Credit for prior coverage will reduce this pre-existing limitation only if proof of coverage is provided at enrollment.

I am submitting proof (Certificates of Health Plan Coverage) with this enrollment. Yes No

DEPENDENT INFORMATION (All eligible dependents MUST be listed below)								
Applicant Relation	Name: Last	First	M.I.	Date of Birth	Gender	Social Security Number	Employed?	If declining coverage for this dependent, indicate reason
Spouse	[]	[]	[]	[] / [] / []	<input type="radio"/> Male <input type="radio"/> Female	[] - [] - []	<input type="radio"/> Yes <input type="radio"/> No	<input type="checkbox"/> Other group coverage <input type="checkbox"/> Medicare/Medicaid <input type="checkbox"/> Other: []
Child	[]	[]	[]	[] / [] / []	<input type="radio"/> Male <input type="radio"/> Female	[] - [] - []	<input type="radio"/> Yes <input type="radio"/> No	<input type="checkbox"/> Other group coverage <input type="checkbox"/> Medicare/Medicaid <input type="checkbox"/> Other: []
Child	[]	[]	[]	[] / [] / []	<input type="radio"/> Male <input type="radio"/> Female	[] - [] - []	<input type="radio"/> Yes <input type="radio"/> No	<input type="checkbox"/> Other group coverage <input type="checkbox"/> Medicare/Medicaid <input type="checkbox"/> Other: []
Child	[]	[]	[]	[] / [] / []	<input type="radio"/> Male <input type="radio"/> Female	[] - [] - []	<input type="radio"/> Yes <input type="radio"/> No	<input type="checkbox"/> Other group coverage <input type="checkbox"/> Medicare/Medicaid <input type="checkbox"/> Other: []
Child	[]	[]	[]	[] / [] / []	<input type="radio"/> Male <input type="radio"/> Female	[] - [] - []	<input type="radio"/> Yes <input type="radio"/> No	<input type="checkbox"/> Other group coverage <input type="checkbox"/> Medicare/Medicaid <input type="checkbox"/> Other: []

OTHER COVERAGE INFORMATION

Is there any other coverage in effect for yourself or for any of your eligible dependents? Yes No

If "Yes", please complete the following:

Name of Primary Insured with Other Coverage _____	Social Security Number _ - _ - _	Relationship to Applicant _____	Employer Name _____	Employer Phone Number _ - _ - _
Name and Address of Other Coverage _____	Coverage Effective Date _ / _ / _	Who is Covered? <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child(ren)	Type of Coverage <input type="checkbox"/> Medical <input type="checkbox"/> Rx <input type="checkbox"/> Vision	

LIFE AND AD&D BENEFICIARY INFORMATION (Applicable only when offered by my employer)

Primary Beneficiary	Name: Last _____	First _____	MI _	Social Security Number _ - _ - _	Relationship to Applicant _____
	Mailing Address: Street _____		City _____	State _	Zip _ _
Secondary Beneficiary	Name: Last _____	First _____	MI _	Social Security Number _ - _ - _	Relationship to Applicant _____
	Mailing Address: Street _____		City _____	State _	Zip _ _

I acknowledge that the available coverages have been explained to me by my employer. I hereby apply for the coverage now being offered to me and my dependents, if any, as shown above. If accepted as a group member, my employer is authorized to deduct the appropriate amount from my earnings and remit it to TACT. I hereby declare that all answers above are true and complete and that any material misstatements or failure to report information may be used as the basis for rescission of coverage for me and my dependents, if any, from the original date. I further understand that if the coverage applied for becomes effective, I will be subject to all the terms of the group policy(ies). I authorize any physician, medical practitioner, hospital, clinic or other medical related facility, insurance company or other organization, employers, or other person that has any information available as to my health or that of any member of my family to give to TACT or its legal representative any such information. I was not induced or pressured into declining coverage because of my health status or that of my dependents, if any. I further understand that in the event I should decide to apply for coverage at a later date, such subsequent application shall be subject to the applicable terms and conditions of the group policy(ies), which may require additional limitations and waiting periods. I understand that I may not be able to apply for this coverage until an annual Open Enrollment Period. A photocopy of this authorization shall be as valid as the original.

Employee Signature

_____/_____/_____
Authorized Employer Signature **(REQUIRED)**

WARNING

It is unlawful to knowingly provide false, incomplete or misleading facts or information for the purpose of defrauding or attempting to defraud. Penalties may include imprisonment, fines, denial of coverage and civil damages.

After filling out the form, please sign and date above and fax to (806) 747-7897.
If you are unable to fax the form, you may mail it to:

Texas Ag Coop Trust
1802 East 50th St, Suite 107
Lubbock, TX 79404