Insurance Company of SCOTT & WHITE
PART OF BAYLOR SCOTT & WHITE HEALTH

Employer Name	
Group/Division #	
Dental/Division #	
Life/Division #	

(Mandatory)

Group PPO Enrollment Application & Change Form

SECTION 1: REQUESTED ACTION		**Please check all that apply – Complete section 5 if declining coverage**			
√	**New Enrollee**	√	**Termination**	√	**Change**
☐	Open Enrollment	☐	Terminate **Medical** Coverage (All Members)	☐	Add Dependent(s)
☐	**New Hire/Rehire**	☐	Terminate **Medical** Dependent(s) Coverage	☐	Change Plan Option
☐	Birth/Adoption	☐	Terminate **Dental** Coverage (All Members)	☐	Demographic Change(s)
☐	Late Enrollee	☐	Terminate **Dental** Dependent(s) Coverage		**HIRE DATE:**__________________ **(Mandatory)**
☐	Marriage Date(Proof of Marriage Required)	☐	Terminate **Life** Coverage (Employee Only)		
☐	Loss of Coverage (Proof of Loss Required)	Reason:____			
☐	Court Order (Court Order or Decree Required)	____			**TERM DATE:**__________________

SECTION 2: EMPLOYEE INFORMATION

First Name	MI	Last Name	Suffix
* Social Security Number	Date of Birth (MM/DD/YYYY)	☐ Male ☐ Female	Employment Status: ☐ Exempt ☐ Non Exempt ☐ Retired
Marital Status ☐ Single/Divorced/Widow ☐ Married ☐ Other__________________		Primary Language: ☐ English ☐ Spanish ☐ Other (Please Specify):________________________	

Residential Address	Apt	City	State	Zip	County
Mailing Address (If different than above)	Apt	City	State	Zip	County

Primary Phone Cell ☐ Landline ☐	Secondary Phone Cell ☐ Landline ☐
Email Address	Preferred Contact Method ☐ Email ☐ Mail
Do you have a disability affecting your ability to communicate or read? ☐ Yes ☐ No	
Will you enroll in Dental Coverage? ☐ Yes ☐ No	Will you enroll in Life Insurance Coverage? ☐ Yes ☐ No

SECTION 3: DEPENDENT INFORMATION

DEPENDENT	First Name	MI	Last Name		Suffix
	* Social Security Number	Date of Birth (MM/DD/YYYY)	☐ Spouse ☐ Child ☐ Grand Child		☐ Male ☐ Female
	Disability affecting your ability to communicate or read? ☐ Yes ☐ No		Primary Language: ☐ English ☐ Spanish ☐ Other		
	Will you enroll in Dental Coverage? ☐ Yes ☐ No		Will you enroll in Life Insurance Coverage? ☐ Yes ☐ No		
DEPENDENT	First Name	MI	Last Name		Suffix
	* Social Security Number	Date of Birth (MM/DD/YYYY)	Relationship ☐ Child ☐ Grand Child		☐ Male ☐ Female
	Disability affecting your ability to communicate or read? ☐ Yes ☐ No		Primary Language: ☐ English ☐ Spanish ☐ Other		
	Will you enroll in Dental Coverage? ☐ Yes ☐ No		Will you enroll in Life Insurance Coverage? ☐ Yes ☐ No		
DEPENDENT	First Name	MI	Last Name		Suffix
	* Social Security Number	Date of Birth (MM/DD/YYYY)	Relationship ☐ Child ☐ Grand Child		☐ Male ☐ Female
	Disability affecting your ability to communicate or read? ☐ Yes ☐ No		Primary Language: ☐ English ☐ Spanish ☐ Other		
	Will you enroll in Dental Coverage? ☐ Yes ☐ No		Will you enroll in Life Insurance Coverage? ☐ Yes ☐ No		
DEPENDENT	First Name	MI	Last Name		Suffix
	* Social Security Number	Date of Birth (MM/DD/YYYY)	Relationship ☐ Child ☐ Grand Child		☐ Male ☐ Female
	Disability affecting your ability to communicate or read? ☐ Yes ☐ No		Primary Language: ☐ English ☐ Spanish ☐ Other		
	Will you enroll in Dental Coverage? ☐ Yes ☐ No		Will you enroll in Life Insurance Coverage? ☐ Yes ☐ No		

*If someone needs help getting a SSN, call (800)772-1213 or visit socialsecurity.gov. TTY users should call (800)325-0778.

Employer Name	
Group/Division #	
Dental/Division #	
Life/Division #	

(Mandatory)

SECTION 4: OTHER COVERAGE	
Will you or your dependents, applying for coverage, be covered under another group health plan? ☐ Yes ☐ No (If yes, complete below)	
Insurance Company Name	Name of Policyholder

SECTION 5: DECLINATION OF COVERAGE
If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself of your dependents in this plan, provided that you request enrollment within 31 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption. ☐ I decline enrollment in the Insurance Company of Scott and White during my initial eligibility period due to the reason listed below.(**employee)** ☐ I decline enrollment in the Insurance Company of Scott and White for my **dependents** during my initial eligibility period due to the reason listed below.
Reason for Declining Coverage:
☐ I and/or my dependents are covered under another health plan benefits plan. Other:
I have not been discouraged by Group or Health Plan from enrolling for coverage.

SECTION 6: ACKNOWLEDGMENT SIGNATURE		
I hereby certify to the best of my knowledge the answers given are correct, truthful, and complete. Further, I hereby authorize my licensed physician, medical practitioner, hospital, clinic or other medically related facility, organization, institution, or person, that has any records or knowledge of me, my family or our health, to give Insurance Company of Scott and White any such information requested. A photographic copy of this authorization shall be valid. I understand that I or my dependents may be covered by another group insurance and I will cooperate fully with the health Plan in providing information necessary to coordinate benefits.		
Signature:	Print Name:	Date (MM/DD/YYYY)

Send completed application by one of the following methods:	**Email:**	Email: swhpgroupenrollment@sw.org ***Subject line: Group Name/Group Number/Division***
	Fax:	Fax 254-298-3199
	Mail:	Scott & White Health Plan MS-A4-126 1206 West Campus Drive Temple, TX 76502
	Portal:	If applicable If experiencing issues with application on portal, please email swhpgroupenrollment@sw.org with Request ID#.