

Health Plus

**SCOTT & WHITE
HEALTH PLAN**

Texas Friendly

**Courtesy Roll/
Change Plan
Enrollment
Application**

For Office Use Only:	Rep _____
Requested Effective Date:	_____
Member # _____	Premium _____
Primary Name _____	
Date Sent to membership ___/___/___	
Date New Plan Coverage Effective ___/___/___	
Payment- Int: CC	Paid / Ong: ACH EPAY CPN
RX	LIFE DENTAL

Courtesy Roll (Available for Health Plus members that wish to change to comparable or lower benefit plan.)

Instructions: Print all information in blue or black ink. All questions must be answered. If you need to make a correction to the application, please line through the incorrect data and initial the correction. Whiteout of changes may result in voiding your application.

A. PLAN SELECTION – ONE (1) Plan type must be chosen, to prevent a delay in your application process.

Health Plus HMO Plan

Health Plus V

You have the option to choose one of the Consumer Choice Health Maintenance Organization health care plans below that, either in whole or in part, do not provide state-mandated health benefits normally required in evidences of coverage in Texas. These standard health benefit plans may provide a more affordable health plan for you although, at the same time, they may provide you with fewer health plan benefits than those normally included as state-mandated health benefits in Texas. If you choose a standard health benefit plan, please consult with your Sales Representative to discover which state-mandated health benefits are excluded in this evidence of coverage.

Portfolio 80 Plans

- | | | |
|-------------------------------|-------------------------------|-------------------------------|
| <input type="checkbox"/> 500 | <input type="checkbox"/> 750 | <input type="checkbox"/> 1500 |
| <input type="checkbox"/> 2500 | <input type="checkbox"/> 5000 | <input type="checkbox"/> 7500 |

Portfolio 70 Plans

- | | |
|-------------------------------|--------------------------------|
| <input type="checkbox"/> 7500 | <input type="checkbox"/> 10000 |
|-------------------------------|--------------------------------|

\$aver Plans (HSA Compatible, includes Rx after deductible)

- | | |
|-------------------------------|-------------------------------|
| <input type="checkbox"/> 3000 | <input type="checkbox"/> 5000 |
|-------------------------------|-------------------------------|

RETURN BY: <u>Mail:</u>	Scott & White Health Plan Attention Health Plus 2401 South 31 st Street Temple, TX 76508	<u>Fax:</u> Attention Health Plus 254-298-3567
		<u>Email:</u> hponline@swmail.sw.org

B. PRIMARY APPLICANT INFORMATION

1. Social Security #	2. Name-Last	First	MI	Maiden Name
3. Mailing Address: City, State and Zip			4. Email Address:	
5. Physical Address (if P.O. Box is listed in #3):			May we contact you by email? <input type="checkbox"/> Yes <input type="checkbox"/> No	
6. Home Phone: ()		7. Alternate Phone: ()		
8. Name of Spouse:		9. Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Legally Married <input type="checkbox"/> Other _____		
10. Is English your primary language? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, please list your primary language.				
11. Do you have a disability which affects your ability to communicate or read? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please describe:				

C. DEPENDENT APPLICANT(S) INFORMATION

12. Please provide the following information about the dependents (including your spouse) you wish to cover. To be eligible for coverage as a dependent child, a child must be under the age of 25 and unmarried. To be eligible for coverage as a spouse, a person must be the subscriber's legal spouse under the laws of the State of Texas. Eligibility will be determined by the criteria established in the Individual Health Care Evidence of Coverage. Be sure to list any dependent's last name if it is different from the subscriber's last name.

Name	Social Security #	Relationship * If adoptee, please answer # 13.	Birthdate (mo/day/yr)	Sex M/F
Spouse:				
Child:				
Child:				
Child:				
Child:				

*13. What was the date the adopted child was placed with you? _____ Reference # _____

D. ACKNOWLEDGMENT (must be signed by the applicant if applying for Health Plus Portfolio or \$aver).

I am aware that choosing this Consumer Choice of Benefits Health Maintenance Organization health care plan that either in whole or in part, does not provide state-mandated health benefits normally required in evidences of coverage in Texas. This standard health plan benefit may provide a more affordable health plan for you although, at the same time, it may provide you with fewer health plan benefits than those normally included as state-mandated health benefits in Texas. If you choose this standard health benefit plan, please consult with your Sales Representative to discover which state-mandated health benefits are excluded in this evidence of coverage.

Primary Applicant's Signature: _____ Date: _____

**CONTINUED ON NEXT PAGE
PLEASE BE SURE TO SIGN AND DATE PAGE 3!**

E. CERTIFICATION AND AUTHORIZATION FOR RECORDS RELEASE

This enrollment application must be updated to include any change in health status or impairment, including pregnancy, which occurs between the date of application and the date of becoming a member. Failure to provide this information to the Scott & White Health Plan will constitute a misrepresentation of the presence of a pre-existing condition, impairment or disease that will void your coverage when discovered.

I understand that coverage with Scott & White Health Plan is not automatic. The information provided by me on this application is used by Scott & White Health Plan and is material to its decision to either, accept or decline my coverage. I therefore certify that the information that I have provided is truthful, complete, and made to the best of my knowledge and belief. I acknowledge that any incorrect or incomplete information contained in this application may cause Scott & White Health Plan to void my coverage, if it is determined, that had this information been disclosed on the application, the Scott & White Health Plan would have declined my coverage. If I become aware of any requested information that should be corrected or made complete prior to Scott & White Health Plan's acceptance of this application, or at any time in the future, I will inform Scott & White Health Plan or my coverage will be voided from the date of issuance.

Further, I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, the Medical Information Bureau or other organization, institution, or person, that has any records or knowledge of me or my family's health, to give to the Scott and White Health Plan, or its reinsurers any such information that it may request if permitted by law, including but not limited to any information pertaining to psychiatry/psychology, drug/alcohol usage, and HIV/AIDS. I understand that my authorized disclosure of protected health information carries with it the potential for re-disclosure and may no longer be protected by the Federal privacy laws. I understand that I may revoke this authorization in writing at any time, except to the extent that Scott & White Health Plan or any health care provider has already relied on this authorization. I understand that I may revoke this authorization by providing Scott & White Health Plan with a written request for revocation stating my intent to revoke this authorization. This authorization expires 24 months from the date the authorization is signed. Scott & White Health Plan may deny you enrollment or eligibility for benefits if you fail to complete this authorization form.

I understand that Scott & White Health Plan may not have conducted a review of my medical records or obtained copies of my records from all of my doctors, clinics, and other health facilities. To the extent allowed by law, if Scott & White Health Plan later finds evidence of a medical condition which I did not list on this form and which could legally be used to deny coverage, the Scott & White Health Plan will terminate my coverage. I understand that in the absence of complete medical records, a general physical may be required and will be at the applicant's expense.

Upon decision, I will receive notification by mail. If the application has been approved, the initial monthly premium payment must be paid in advance prior to the issuance of an agreement. The notification will include premium amount and deadline for remittance.

I understand that medical information acquired by Scott & White Health Plan is confidential and protected by law. In this regard, I understand that Scott & White Health Plan employees are not allowed to reveal Scott & White Health Plan's basis for approval or denial, of my application unless Scott & White Health Plan is required to reveal that basis through legal process. Scott & White Health Plan will not approve or deny my application on any basis which is prohibited by law.

I hereby certify that to the best of my knowledge the answers given are current, truthful, and complete.

A photographic copy of this authorization shall be as valid as the original.

Signed at _____ this _____ day of _____, 20____
(City) (State) (# day) (Month) (Year)

Print Name of Primary Applicant

Signature of Primary Applicant

Print Name of Spouse (if applying)

Signature of Spouse (if applying)

Print Name of Dependent (if applying)

Signature of Parent or Guardian of Dependent (if applying)

Print Name of Dependent (if applying)

Signature of Parent or Guardian of Dependent (if applying)

Print Name of Dependent (if applying)

Signature of Parent or Guardian of Dependent (if applying)

Print Name of Dependent (if applying)

Signature of Parent or Guardian of Dependent (if applying)