

Health Plus



Texas Friendly

2011 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.

**NOTE: Deductibles start over when your plan changes become effective.
These plans renew November 1, 2011, so rates may change on this date.**

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

HMO Plan

Traditions

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.

Engage 80 Plans (deductible with 20% co-insurance)

750 1,500 2,500 5,000 7,500 10,000

Engage 70 Plans (deductible with 30% co-insurance)

5,000 7,500 10,000

Saver Plans (include Rx 3000 benefit)

3,000 5,000

Prescription Plans:

Rx 3000 (benefit - \$3,000; 50% coverage after benefit exhausted)

RETURN BY: Mail: Scott & White Health Plan
Attention Health Plus
1206 West Campus Drive
Temple, TX 76502

Fax: Attention Health Plus
254-298-3567

Email: hponline@swmail.sw.org

B. PRIMARY APPLICANT INFORMATION

1. Social Security Number	2. Name (Last / First / MI)	Maiden Name
3. Mailing Address (City/State/Zip) <i>Is this a new mailing address?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No		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. Preferred Phone: ()	Are either of these telephone numbers <input type="checkbox"/> Yes <input type="checkbox"/> No	
7. Alternate Phone: ()	new contact numbers?	
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 26 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 Number	Relationship* <i>(If adoptee, please answer # 13)</i>	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 Saver).

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: _____