Individual & Family Plans

Preferred Provider Organization (PPO)

Enrollment Application

If you have questions, please contact a sales representative at 1-866-522-2515,
Monday – Friday, 8:00 AM – 5:00 PM.

Submit by Fax: **Attention Individual & Family Plans**	**Submit by mail:** **Insurance Company of Scott & White** **Attention Individual & Family Plans**
979-846-6962 **512-930-6055** **325-659-1549** **254-298-3567** **254-756-8080**	**3000 Briarcrest, Suite 422, Bryan, TX 77802** **204 S. IH-35, Suite 100, Georgetown, TX 78628** **1131 Knickerbocker, Suite B, San Angelo, TX 76903** **1206 West Campus Drive, Temple, TX 76502** **200 W. State Highway 6, Suite 300, Waco, TX 76712**

APPLICATION INSTRUCTIONS

1. This application must be completed with black or blue ink only. Illegible applications or applications completed in pencil or erasable ink will be returned. Changes or corrections to this application must be made by drawing a line through the change/mistake and initializing the change. DO NOT use correction tape or fluid.

2. Questions must be answered with complete details given for any "yes" answers. You are responsible for the accuracy and completeness of all information entered on this form. Full disclosure is essential in processing your application. Any misrepresentation or omission of the presence of an existing condition, impairment or disease will be subject to medical review, upon discovery, and if determined to be fraud or intentional misrepresentation, rescission of the policy. Incomplete applications may result in delays and/or declination. **If more space is needed, attach a separate page(s) and list section(s) and question number(s) then sign and date each page.**

3. The Insurance Company of Scott & White Plans for Individuals and Families are not guaranteed issue plans. All applicants, age 19 and older, enrolling including spouse and dependents are subject to medical underwriting to determine premium.

4. All legal-age applicants or the parent/legal guardian of a minor child applicant must personally sign and date this application. If your spouse or any dependent(s) age 18 or over are also applying for coverage, they must personally sign and date this application on the appropriate signature line.

Individual and Family Plans
Insurance Company of SCOTT & WHITE
The one Texans trust.

Office Use Only: Sales Rep:___________ Prem: ________

Application for Health Insurance

SECTION 1: APPLICATION INFORMATION

☐ New Application ☐ Reapplication ☐ Add Member ☐ Add Newborn/Adoption ☐ Upgrade
☐ Information Change (describe): ____

How did you hear about ICSW plans? ☐ Broker ☐ Newspaper ☐ TV ☐ Radio ☐ Door Hanger ☐ Other ______________

SECTION 2: APPLICANT (s) INFORMATION

Primary Applicant: **Reference #:**______________

Last Name:	First Name:	MI:	Maiden/Other Name:	SS#

Gender ☐ M ☐ F	Birth date: ___/___/___	Age:	Height: ___'___"	Weight: _____lbs	Email:

Mailing Address :	City:	State:	Zip:
Residential Address:	City:	State:	Zip:

Home or Cell/Work phone: ( ) ( )	Occupation: (e.g. Plumber, Nurse)	Name of Employer and Zip Code:	☐ Single/Divorced/Widow ☐ Legally Married ☐ Other: __________

Do you have a disability which affects your ability to communicate or read? ☐ YES ☐ NO If "Yes", please describe.	List your primary language:	If Spouse is applying on this application please provide spouse's occupation:

Other Applicants: Legal spouse / dependent children (dependent children must be under age 26).

Spouse Child Adoptee*	Name				Gender	DOB	Age	SS#	Height	Weight
	Last:	First:	MI	Maiden/ Other						
Spouse					M ☐ F ☐	/ /			' "	lbs
Child01					M ☐ F ☐	/ /			' "	lbs
Child02					M ☐ F ☐	/ /			' "	lbs
Child03					M ☐ F ☐	/ /			' "	lbs
Child04					M ☐ F ☐	/ /			' "	lbs
Child05					M ☐ F ☐	/ /			' "	lbs
Child06					M ☐ F ☐	/ /			' "	lbs
Child07					M ☐ F ☐	/ /			' "	lbs
Child08					M ☐ F ☐	/ /			' "	lbs

***If adoptee, give the date the adopted child was placed with you:** ____________________

If any one applicant is denied coverage, do you wish to cover the remaining applicants? ☐ Yes ☐ No

SECTION 3: MEDICAL COVERAGE OPTIONS

My Plan 70/50	Deductibles:	☐ $2,500	☐ $5,000	☐ $7,500	☐ $10,000	
My Plan 80/50	Deductibles:	☐ $1,500	☐ $2,500	☐ $5,000	☐ $7,500	☐ $10,000
My Plan 100/70	Deductibles:	☐ $7,500	☐ $10,000	☐ $15,000	☐ $20,000	
My Plan Saver IV 100 /70	Deductibles:	☐ $2,500	☐ $3,500	☐ $5,000		

SECTION 4: OTHER COVERAGES INFORMATION

1. Has any person applying for coverage currently or previously had Scott & White Health Plan coverage, either as a primary insured, spouse or dependant within the last five years? If "Yes", list individual(s) and dates: ______________________________ Yes ☐ No ☐

2. Have you or anyone listed on this application had medical coverage denied, rated up or been given an exclusionary waiver by a health insurance company? If "Yes", list individual(s), date(s), and reason(s): Yes ☐ No ☐

3. Have you or anyone listed on this application had health or major medical coverage (including Medicare or Medicaid) in the last 24 months? If "Yes", please complete the following: Yes ☐ No ☐
Name(s) of all covered: ______________________________
Insurer Name(s): ______________________________
Policy Effective Date:__________________Policy Termination Date:__________________

SECTION 5. PHYSICIAN/FACILITY INFORMATION (FOR ALL APPLICANTS)

If you answer "Yes" to the following questions, please fill in an answer for each section in the Medical Care Giver's Table below. If additional space is needed, please list on a separate sheet.

☐ ***Check box if attachment is enclosed***

Question	Answer
1. Does anyone have a personal physician?	Yes ☐ No ☐
2. Has anyone seen any other physician(s) for any reason in the last five (5) years?	Yes ☐ No ☐
3. Has anyone seen any other type of medically trained care giver, such as but not limited to a chiropractor, physical therapist or psychologist in the last 2 years?	Yes ☐ No ☐

Medical Care Giver's Table

Name of Applicant	Date of last visit	# of years under Physician/ Care Giver's Care	Reason for visit	Physician Information (*Missing information will delay the application process.)*
				Dr: ____ Address: ____ Phone: (____) ____
				Dr: ____ Address: ____ Phone: (____) ____
				Dr: ____ Address: ____ Phone: (____) ____
				Dr: ____ Address: ____ Phone: (____) ____
				Dr: ____ Address: ____ Phone: (____) ____
				Dr: ____ Address: ____ Phone: (____) ____
				Dr: ____ Address: ____ Phone: (____) ____

SECTION 6: MEDICATION INFORMATION (ALL APPLICANTS)

1. Has anyone taken any prescription medications in the last twenty-four (24) months? If "Yes", list all medications below. **If additional space is needed please list on a separate sheet.** Yes ☐ No ☐

☐ ***Check box if attachment is enclosed***

Name of Applicant	Prescribing Physician	Name of Drug	Strength (if known) (e.g., 50 mg tablet)	Dosage / Frequency				Date First Started	Date Ended (if applicable)
				Number Taken		Refill Information			
				Day	Mo	Qty per fill	# of yearly fills		
John EXAMPLE	*Dr. Bob Smith*	*Zoloft*	*.50*	*2*		*60*	*12*	*3/99*	*12/06*

SECTION 7. MEDICAL QUESTIONNAIRE

- **"To the best of your knowledge or belief, do you or anyone applying on this application currently have, had in the past or been diagnosed with any of the following conditions?" All health history and medical questions must be completed for all individuals (including adults and children) applying for coverage.**
- **If you answer "Yes" to any question in Section 7, PLEASE GIVE COMPLETE DETAILS IN Section 8 and include the date(s) the conditions began, the recovery dates (if applicable) for all conditions, injuries, symptoms, and diagnoses.**
- **Has any person applying for coverage ever been advised, counseled, tested, diagnosed, treated, prescribed medication, hospitalized or recommended for treatments for the following conditions:**

Question	Answer
Male Applicants only:	
1. Problems with prostate, infertility, impotence or abnormal PSA test?	☐ Yes ☐ No
Female Applicants only:	
2. Have you had a menstrual period within the last 31 days? ***(If "Yes", please give date and verify that it was normal in Section 8.)*** ***(If "No", please give date of last menstrual period and explain why in Section 8.)*** ***(If "Never had one" and over age 13, please explain why in Section 8.)***	☐ Yes ☐ No ☐ Never had one
3. Was last Pap smear normal? ***(If "Yes", please give date & facility in Section 8.)*** ***(If "No", please give date, facility and explain in Section 8.)*** ***(If "Never had one" and are 19 years of age, explain in Section 8.)***	☐ Yes ☐ No ☐ Never had one
4. Currently pregnant, possibly could be pregnant? Or had a positive home pregnancy test in the last 90 days?	☐ Yes ☐ No
5. Any history of or currently have abnormal vaginal bleeding, bleeding between periods or following (menopause), endometriosis, polycystic ovarian disease, pregnancy complications, miscarriage, abortion, treated for or advised to have infertility treatment or any other reproductive problems?	☐ Yes ☐ No
6. Had an abortion(s)?	☐ Yes ☐ No
7. Lump(s) in breast, breast disease or disorder, or abnormal mammogram?	☐ Yes ☐ No

All Applicants:	
8. Used tobacco products of any kind? ***If "Yes", list what was used, how long it was used, and, if applicable, the quit date (month/year). (Give details in Section 8.)***	☐ Yes ☐ No
9. Any alcohol usage? ***If "Yes", list type of alcohol and number of ounces per week. (Give details in Section 8.)***	☐ Yes ☐ No
10. Any substance use including narcotics, illegal prescriptions, street drugs, marijuana and/or any other mind-altering substances currently being used or used within the last ten (10) years? ***If "Yes", please list substance used, dates, and amount consumed. (Give details in Section 8.)***	☐ Yes ☐ No
11. Treated, recommended to have treatment, or been counseled to decrease use of a substance, narcotic or alcohol use?	☐ Yes ☐ No
12. Skin problems, abdominal pain, hernia, indigestion or heartburn, constipation, diarrhea or bowel changes, ulcer, bleeding problems including rectal or gastrointestinal, black or tarry bowel movements, yellow jaundice, hepatitis, positive test for hepatitis B or C, problems with gallbladder, reflux, throat/esophagus, stomach, intestinal, liver, pancreas, blood in your vomit, anemia and/or blood disorders?	☐ Yes ☐ No
13. Ear or eye problems, hearing or vision loss, cataracts, glaucoma, tonsillitis/throat or swallowing problems, and/or any other ear, eye or throat disorders?	☐ Yes ☐ No
14. Asthma, bronchitis, emphysema, COPD, pneumonia, allergies, wheezing, cough, shortness of breath, coughing up blood, TB, night sweats and/or any other lung disorders?	☐ Yes ☐ No
15. Broken bones, back/neck pain, pain or swelling around joints, knees and hips, arthritis, gout, rheumatism, pain or pain syndromes, chronic fatigue syndrome, fibromyalgia, popping or locking of jaw, TMJ, and/or any other musculoskeletal disorders?	☐ Yes ☐ No
16. Is any applicant, male or female, now or have been in the last 6 months an expectant parent or in the process of adoption or surrogacy?	☐ Yes ☐ No
17. Weight change more than 20 pounds in the past year? ***If "Yes", list how many pounds – up/down – and reason. (Give details in Section 8.)***	☐ Yes ☐ No
18. Urinary tract or kidney infection, bladder or kidney stones, loss of urine control, urinary retention, urinary or renal insufficiency, dialysis, pain or burning when urinating, blood, albumin, protein, pus or sugar in urine?	☐ Yes ☐ No
19. Has anyone ever had any surgery, illness or injury that required hospitalization or ER visit?	☐ Yes ☐ No
20. Has anyone applied for or received Worker's Compensation or any other insurance disability benefits?	☐ Yes ☐ No
21. Has anyone ever been rejected by the armed services, denied any type of license, or denied or rated up for a policy or coverage by any health or life insurance company for health reasons?	☐ Yes ☐ No
22. Have you lived outside of the United States in the last year? ***If "Yes" give name of other country and date of when you moved to the United States in Section 8.***	Yes ☐ No ☐
23. Headaches, migraines, dizziness, seizures, epilepsy, convulsions, loss of control of hand/foot, stroke, Parkinson's or Alzheimer's Disease, numbness, TIA, paralysis, temporarily loss of ability to speak, fainted/lost consciousness and/or any other neurological conditions?	☐ Yes ☐ No
24 Sexually transmitted diseases, such as gonorrhea, syphilis, herpes, pelvic inflammatory disease, Chlamydia, HPV, etc.	☐ Yes ☐ No
25. Been diagnosed or treated for any congenital or acquired immune deficiency syndromes, AIDS, or AIDS Related Complex (ARC) or had any positive test for AIDS or HIV?	☐ Yes ☐ No
26. Any autoimmune disease, such as lupus, scleroderma, muscular sclerosis, rheumatoid arthritis and/or any other disorders of the immune system?	☐ Yes ☐ No
27. Diabetes, pre-diabetes, glucose intolerance, metabolic syndrome, endocrine disorder, thyroid Disease or disorder, goiter, pituitary or adrenal disorders and/or weight problems?	☐ Yes ☐ No
28. Ever had "abnormal" results to any diagnostic test, such as: blood test, urinalysis, blood pressure, X-ray, MRI, CT and/or EKG?	☐ Yes ☐ No
29. Any high blood pressure or hypertension? ***If "Yes", please list last 3 readings and dates. (Give details in Section 8.)***	☐ Yes ☐ No
30. Had elevated cholesterol, triglyceride or lipids level readings? ***If "Yes", please list levels. (Give details in Section 8.)***	☐ Yes ☐ No

Question	Answer
31. Any heart disease, cardiovascular disorders, heart murmur, pacemaker, heart valve, varicose veins, phlebitis, deep vein thrombosis, heart attack, chest pain, congestive heart failure, abnormal heart rate or rhythm, vascular disease, rheumatic fever and/or any other circulatory or heart disorders?	☐ Yes ☐ No
32. Participate in any extreme sports or hobbies such as motor speed events, rodeo riding, rock climbing, scuba diving, etc?	☐ Yes ☐ No
33. Hallucinations, insomnia, trouble falling asleep or staying asleep, feel tired after a good night's sleep, eating disorder, anxiety, nervousness, depression, bipolar, psychotic disorder, ADD, ADHD, developmental disorder, autism/autism spectrum disorder, schizophrenia, neurosis, or any other behavioral or mental health condition?	☐ Yes ☐ No
34. Any type of Cancer, lymphoma, leukemia, melanoma, tumor or transplant?	☐ Yes ☐ No
35. Has any applicant ***NOT*** completed recommended routine immunizations and screening exams?	☐ Yes ☐ No
36. Is anyone currently receiving or been advised to have any type of medical treatment, surgery, therapy, or diagnostic tests for any other medical condition that you have not yet explained in this application?	☐ Yes ☐ No

If you answered "Yes" to any question in Section 7, please give complete details in Section 8.

SECTION 8: DETAILS OF HEALTH HISTORY

If you answered "yes" to any question in Section 7 for any applicants, please provide complete additional details in the spaces below. **If additional space is needed, please list and include on a separate sheet.**

☐ ***Check box if a separate sheet/attachment is enclosed***

Question #:	Applicant Physician/Hospital/Clinic Name/Address/Phone (with area code)	Condition, Injury, Symptom or Diagnosis: Description (specify left or right, if applicable	Condition, Injury, Symptom or Diagnosis: Date started	Was recovery complete? If yes, give date of complete recovery	Types of treatment including medication, surgery or procedures
29	Applicant Name: *John Jones* Dr's Name: *Dr. Michael Smith* Address: *1605 Main Street, Temple, TX 76501* (*254*) 123-4567	*High Blood Pressure* **(EXAMPLE)**	*1/95*	*ongoing*	*Stress test; 20 mgBenicar daily. Yes, still taking.9/15/10: 124/80; 10/15/10: 127/80; 1/15/11: 120/80*
	Applicant Name: Dr's Name: ____ Address: ____ (____)____				
	Applicant Name: Dr's Name: ____ Address: ____ (____)____				
	Applicant Name: Dr's Name: ____ Address: ____ (____)____				

	Applicant Name:				
	Dr's Name: ____Address: ____ (__________)____				
	Applicant Name:				
	Dr's Name: ____ Address:____ (__________)____				
	Applicant Name:				
	Dr's Name: ____ Address:____ (__________)____				
	Applicant Name:				
	Dr's Name: ____ Address: ____ (_________)____				

6. **Replacement of Coverage** Will this insurance replace any health insurance currently in force? If "Yes", please read the **Notice to Applicant** below and complete the following: List all coverage that will be replaced					Yes ☐ No ☐
Name(s) of all Insured	Name Of Company	Policy Number	Policy Effective Date	Policy Termination Date	I have read the "**Notice to Applicant"** below.
					Yes ☐ No ☐

Notice to Applicant

Regarding Replacement of Accident and Sickness Insurance

If "Yes" is- indicated above, you intend to lapse or otherwise terminate existing accident and sickness insurance and replace it with a contract to be issued by Insurance Company of Scott & White. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new contract.

A. Health conditions which you may presently have may not be immediately or fully covered under the new contract. This could result in denial or delay of a claim for benefits under the new contract, whereas a similar claim might have been payable under your present contract.

B. You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present contract. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.

C. If, after due consideration, you still wish to terminate your present contract and replace it with new coverage, be certain to truthfully and completely answer all questions on this application concerning the medical/health history of any person applying for coverage. Failure to include all material medical information on any application may provide a basis for the company to deny any future claims and to refund your premium as though your contract had never been in force. After the application has been completed and before you sign it, re-read it carefully to be certain that all information has been properly recorded.

D. It is recommended that you not terminate your present contract until you are certain that your application for the new contract has been approved by Insurance Company Scott & White Underwriting.

SECTION 10: BILLING INFORMATION

Authorization Agreement for Prepayments (Insurance Company of Scott & White (ICSW) Individual & Family Plans):

If approved, your coverage will become effective on the first (1st) day of the month following the date of approval.

ICSW Individual & Family plans are pre-paid health insurance coverage, which means you pay your initial premium payment and subsequent payments for coverage prior to the month of coverage. Please select your premium payment option below by putting a "check mark" in the appropriate box and then completing the corresponding financial information. Your coverage will become effective on the first of the month following approval, per your specified effective date selection. If you are approved for coverage, you will receive an acceptance letter with notification of the effective date of coverage with the names of each individual applicant who has been approved for coverage, plus the premium amount that has been charged to your account. You may change the method of your premium payments by contacting ICSW online Customer Service via email at "SWHP.org" or by calling 866-334-3141, Monday – Friday, 8:00 AM – 5:00 PM. (Any change in the method of payment will be dependent on the time of month the request is made and the type of payment method requested.)

Any initial premium payments sent before acceptance by ICSW will not constitute approval or acceptance of health insurance coverage or bind coverage by ICSW, including but not limited to any deposit, negotiation, or holding of such premiums or payments by ICSW. I understand and agree that not withstanding anything in the application to the contrary; no coverage shall be considered accepted until approved by ICSW.

Initial Payment Option: ☐Credit/Debit Card ☐ Bank draft (*Only if received before your coverage effective date*)
☐ Check/Money Order (Make checks payable to the Insurance Company of Scott & White)

Ongoing Premium Payment Option: (select 1 of the 3 payment options)

☐Automatic Bank Draft ☐ Coupon (Pay monthly by check/money order)
☐Pay Online ***payments must be made by you,* using your credit card and going to the web site www.swhp.org**

Credit /Debit Card Information:

☐MASTERCARD ☐ VISA ☐ DISCOVER ☐AMERICAN EXPRESS
Card Account #: ___ ___ ___ ___ - ___ ___ ___ ___ - ___ ___ ___ ___ - ___ ___ ___ ___
Name on Card: ______________________________ Card Expiration Date: _______/_______
Card Billing Address (address where you receive your credit card statements):
Street Address: ____
City: ______________________ State: ________________ Zip Code: ____________
Signature: ______________________________________ Date: ________________

Automatic Bank Draft information*: Occurs between 4th and 9th of the month*

☐ Checking Account ☐ Savings Account
Name of Financial Institution: ____
Account Number: ______________________ Routing Number: ______________________
Name on Account: ____
Authorized Signature for Account: ______________________________ Date: ____________
Contract Holder:
Print Name: ____________________ Signature: ______________________ Date: ____________

For Office Use Only:
Draft Effective Date: ______________________ Submitted By: ______________________

Contract ID Number: ______________________

SECTION 11: CERTIFICATION AND AUTHORIZATION FOR RECORDS RELEASE

This enrollment application must be updated to include any change in health status or medical impairment, including pregnancy, which occurs between the signature date of this application and the date of becoming an insured member. Failure to provide this information to the ICSW will constitute a misrepresentation of the presence of an existing condition, impairment or disease that will be subject to medical review, upon discovery, and, if determined to be fraud or intentional misrepresentation, rescission of the policy.

I understand that coverage with Insurance Company of Scott & White (ICSW) is not automatic. The information provided by me on this application is used by ICSW 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 that is determined to be fraud or intentional misrepresentation may cause ICSW to void my coverage, if it is determined, that had this information been disclosed on the application, that ICSW would have declined my coverage.

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 ICSW, or its reinsurers or business associates, any such medical or treatment 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 also grant ICSW to disclose the reason(s) and source for any denial of coverage to my designated broker (if applicable) and to myself and to my physician, if requested. This includes release of information obtained through claims, telephone interview, medical records, or third-party databases. 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 ICSW or any health care provider has already relied on this authorization. I understand that I may revoke this authorization by providing ICSW 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. ICSW may deny my enrollment or eligibility for benefits if I fail to complete this authorization form.

I understand that ICSW 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 ICSW 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 ICSW will terminate my coverage. I understand that in the absence of complete medical records, a general physical may be required and will be at my own expense.

Upon review of my application, I will receive notification by mail of my insurability. If the application has been approved, the initial monthly premium payment must be paid in advance prior to the issuance of a policy and a notification will be sent which includes the premium amount and the deadline for remittance prior to the effective date of coverage. I understand that medical information acquired by ICSW is confidential and protected by law. In this regard, I understand that ICSW employees are not allowed to reveal ICSW's basis for approval or denial of my application unless ICSW is required to reveal that basis through a legal process and as I grant the authorization to reveal the details to my broker or to myself. ICSW 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 here are current, truthful, and complete. A photographic copy of this authorization shall be as valid as the original.

Print Name of Primary Applicant	Signature of Primary Applicant	Date

If applying (dependents 18 years of age and older must sign for themselves unless parent/guardian has Power of Attorney:

Print Name of Spouse	Signature of Spouse	Date
Print Name of Dependent	Signature of Parent /Guardian of Dependent	Date
Print Name of Dependent	Signature of Parent/Guardian of Dependent	Date
Print Name of Dependent	Signature of Parent/Guardian of Dependent	Date
Print Name of Dependent	Signature of Parent/Guardian of Dependent	Date
Print Name of Dependent	Signature of Parent/Guardian of Dependent	Date

THIS APPLICATION WILL EXPIRE SIXTY (60) DAYS FROM THE ABOVE SIGNATURE DATE