

**ENROLLMENT FORM**

OFFICE USE ONLY

Effective Date \_\_\_\_\_

Term Date \_\_\_\_\_

[  HMO ] [  Consumer Choice HMO ] [  First Dollar ] [  POS ] [  HSA ] [  HRA ]

Social Security Number	Employee-Last Name	Employee-First Name	MI
Mailing Address	City	State	Zip
Date of Birth	Home Phone	Work Phone	<input type="checkbox"/> Male <input type="checkbox"/> Female

Coverage Type:  Employee Only  Employee & Spouse  Employee & Child/Children  Employee & Family

Primary Care Physician \_\_\_\_\_

Have you ever been a member of the Scott & White Health Plan?  Yes  No  
 If yes, Previous Health Plan Employer Group or Contract # \_\_\_\_\_

<b>ADD</b> <input type="checkbox"/> New Hire <input type="checkbox"/> Open Enrollment <input type="checkbox"/> Marriage <input type="checkbox"/> Newborn/Adoption	<input type="checkbox"/> Late Enrollee <input type="checkbox"/> Loss of Coverage (HIPAA Certificate Required) <input type="checkbox"/> Other _____	<b>CHANGE</b> <input type="checkbox"/> Name Change _____ <input type="checkbox"/> Address Change _____ <input type="checkbox"/> COBRA _____	<b>TERMINATE</b> <input type="checkbox"/> Delete Dependent(s) <input type="checkbox"/> Term Contract Reason _____
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Do you have a disability which affects your ability to communicate or read? \_\_\_\_\_ If yes, please describe \_\_\_\_\_

Employer's Name	Group/Division #	Date of Employment
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Employment Status <input type="checkbox"/> Active <input type="checkbox"/> Retired	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Legally Married <input type="checkbox"/> Other _____	What is your primary language
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Please provide the following information about the dependents (including your spouse) you wish to cover. To be eligible for coverage as a dependent, a person must meet the criteria established in the Group Health Care Evidence of Coverage. To be eligible for coverage as a spouse, a person must be legally married to the subscriber, according to the laws of the State of Texas. Be sure to list the dependents' last name if it is different from the subscriber's last name.

Name	Social Security #	Relationship	Primary Care Physician (PCP)	Birthdate	Sex

**FEMALE Members:** You have the right to designate an OB/GYN physician to whom you have access without first obtaining a referral from your Primary Care Physician. You are not required to designate an OB/GYN; you may elect to receive your OB/GYN services from your PCP. If you wish to designate a Scott & White Health Plan Network OB/GYN physician, please list the name of the provider: \_\_\_\_\_

Are you or your spouse Medicare eligible? <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, complete next section)	Medicare No. Enrollee _____ Spouse _____	<b>Self</b> <input type="checkbox"/> A only (hospital) <input type="checkbox"/> A and B (hospital & medical) <input type="checkbox"/> Part D	<b>Spouse</b> <input type="checkbox"/> A only (hospital) <input type="checkbox"/> A and B (hospital & medical) <input type="checkbox"/> Part D
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Will you or your dependents, applying for SWHP Coverage, be covered under another group health plan?  Yes  No  
 (If yes, complete below)

Insurance Company Name	Name of Policyholder
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MetLife® Dental Insurance and Group Term Life is provided by Metropolitan Life Insurance Co.

I hereby certify that to the best of my knowledge the answers given are current, truthful, and complete. Further, I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility or the organization, institution, or person, that has any records or knowledge of me or my family or our health, to give Scott and White Health Plan any such information that it may request. A photographic copy of this authorization shall be as valid as the original. 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.

**ENROLLEE SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_