Baylor Scott & White Health Plan

Group Name	
Top Account Number	
Medical Rider	
Waive New Hire During Open Enrollment	☐ Yes ☐ No

Mandatory

Group Enrollment HMO Application & Change Form

PLAN TYPE______________________

Consumer Choice Benefit Plans: You have the option to choose 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 benefit plan may provide a more affordable health plan for you although, at the same time, it may provide you with fewer health benefits than those normally included as state-mandated health benefits in Texas. If you choose this standard health benefit plan, please consult with your insurance agent to discover which state-mandated health benefits are excluded in this evidence of coverage.

An enrollee may select an obstetrician or gynecologist as their primary care physician, as set forth in the Texas Insurance Code Chapter 1451, Subchapter F. Enrollee may designate the selection here:
Enrollee is not required to select an obstetrician or gynecologist but may instead receive obstetrical or gynecological services from her primary care physician.

SECTION 1: REQUESTED ACTION - Check all the boxes that apply and complete the additional sections that correspond to your selection.

- Hire date is mandatory on all new enrollees and open enrollment elections.
- Late enrollees are not eligible for coverage until the next open enrollment period. Please refer to your coverage documents.
- Enrollment outside of open enrollment must have a qualifying event and be able to produce required documentation.
- Enrollees terminating coverage may be subject to TIC 843.210.
- To avoid delays, please ensure this application is filled out legibly and completely. Incomplete applications **will not** be processed. You can email your completed application to [SWHPGroupEnrollment@BSWHealth.org]. Please allow 5 business days for processing.

If declining coverage, complete Section 2 and 6 (If an employee is currently enrolled and does not wish to renew, the action to request is a termination, not a declination.)

Enrollment Event – Check ALL boxes that apply.

☐ Open Enrollment ☐ New Hire ☐ Current Member	Date of Hire ____________	**Qualifying Event?** ☐ Yes ☐ No *Select the appropriate event and enter event date. Effective date subject to SEP guidelines*		**Termination/Cancellation Date** ____________
☐ Rehire	Date of Rehire ____________	☐ Birth/Adoption **Proof of Adoption Required**	Date of birth/adoption ____________	☐ Terminate Contract *(Enrollee and all dependents)* ☐ Medical ☐ Dental ☐ Life
Other Changes ☐ Add Dependent(s) ☐ Change Plan Option ☐ Address Update ☐ Date of Birth ☐ Name Change ☐ COBRA Start Date ________		☐ Marriage **Proof of Marriage Required**	Date of marriage ____________	☐ Terminate Dependent(s) *Complete Sections 4, 5, and 6*
		☐ Loss of Coverage **Proof of Loss Required**	Date coverage ended ____________	Reason for Termination ☐ Termination of Employment ☐ Retirement ☐ Termination of Benefits ☐ Death: Date ____________
		☐ Court Order **Court Order or Decree Required**	Date of order ____________	

SECTION 2: DECLINATION OF COVERAGE
Retain the form for your records only. The form does not need to be sent to Scott and White Health Plan d/b/a Baylor Scott & White Health Plan for current groups. Waivers are required for new group submissions. If an employee is currently enrolled and does not wish to renew coverage, the action requested is a termination, not a declination.
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 thirty-one (31) days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, placement for adoption, or children who have become the subject of a suit of adoption by the enrollee, you may be able to enroll yourself and your dependents, provided that you request enrollment within thirty-one (31) days after the marriage, birth, adoption, or placement for adoption. ☐ I decline enrollment in Scott and White Health Plan d/b/a Baylor Scott & White Health Plan during my initial eligibility period due to the reason listed below. **(employee) (OR)** ☐ I decline enrollment in Scott and White Health Plan d/b/a Baylor Scott & White Health Plan 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 reason for declining coverage (please specify):

SECTION 3: OTHER COVERAGE (REQUIRED)	
Will you or your dependents, applying for coverage, be covered under another group health plan or Medicare? ☐ Yes ☐ No (If yes, complete below)	
Insurance Company Name	Name of Policyholder ____________________________________ Policy number ____ Coverage start date ____________

SECTION 4: EMPLOYEE INFORMATION – All information in this section is necessary for accurate and timely processing.							
Coverage Selection **Medical** ☐ Add ☐ Term ☐ Change ☐ No Change			**Dental** ☐ Add ☐ Term ☐ Change ☐ No Change				**Life** ☐ Add ☐ Term
* Social Security Number	First Name		MI	Last Name			Suffix
Mailing Address			Apt	City	State		Zip
Residential Address (If different than above)			Apt	City	State		Zip
Primary Phone		Secondary Phone	Email Address				
Employment Status ☐ Active ☐ Retiree ☐ COBRA ☐ Exempt		Marital Status ☐ Single/Divorced/ Widow ☐ Married ☐ Other	☐ Male ☐ Female				Date of Birth ____________
Primary Spoken Language ☐ English ☐ Spanish ☐ Other (please indicate) ___________________		Written Language ☐ English ☐ Spanish ☐ Other (please indicate) ___________________					
Do you have a disability affecting your ability to communicate or read? ☐ Yes ☐ No							

SECTION 5: DEPENDENT INFORMATION – Complete all applicable information in this section.				
List all family members currently active and action needed. Please complete every field in its entirety to ensure correct processing.				
Medical ☐ Add ☐ Term ☐ Demographic Change ☐ No Change	First Name	MI	Last Name	Suffix
	* Social Security Number	☐ Male ☐ Female	Date of Birth ____________	
Dental ☐ Add ☐ Term ☐ Demographic Change ☐ No Change	Primary Language Spoken: ☐ English ☐ Spanish ☐ Other ____________ Written: ☐ English ☐ Spanish ☐ Other ____________		☐ Spouse ☐ Common-law** ☐ Child ☐ Grandchild ☐ Other Eligible Dependent	
	Disability affecting your ability to communicate or read? ☐ Yes ☐ No			
Medical ☐ Add ☐ Term ☐ Demographic Change ☐ No Change	First Name	MI	Last Name	Suffix
	* Social Security Number	☐ Male ☐ Female	Date of Birth ____________	
Dental ☐ Add ☐ Term ☐ Demographic Change ☐ No Change	Primary Language Spoken: ☐ English ☐ Spanish ☐ Other ____________ Written: ☐ English ☐ Spanish ☐ Other ____________		☐ Spouse ☐ Common-law** ☐ Child ☐ Grandchild ☐ Other Eligible Dependent	
	Disability affecting your ability to communicate or read? ☐ Yes ☐ No			
Medical ☐ Add ☐ Term ☐ Demographic Change ☐ No Change	First Name	MI	Last Name	Suffix
	* Social Security Number	☐ Male ☐ Female	Date of Birth ____________	
Dental ☐ Add ☐ Term ☐ Demographic Change ☐ No Change	Primary Language Spoken: ☐ English ☐ Spanish ☐ Other ____________ Written: ☐ English ☐ Spanish ☐ Other ____________		☐ Spouse ☐ Common-law** ☐ Child ☐ Grandchild ☐ Other Eligible Dependent	
	Disability affecting your ability to communicate or read? ☐ Yes ☐ No			
Medical ☐ Add ☐ Term ☐ Demographic Change ☐ No Change	First Name	MI	Last Name	Suffix
	* Social Security Number	☐ Male ☐ Female	Date of Birth ____________	
Dental ☐ Add ☐ Term ☐ Demographic Change ☐ No Change	Primary Language Spoken: ☐ English ☐ Spanish ☐ Other ____________ Written: ☐ English ☐ Spanish ☐ Other ____________		☐ Spouse ☐ Common-law** ☐ Child ☐ Grandchild ☐ Other Eligible Dependent	
	Disability affecting your ability to communicate or read? ☐ Yes ☐ No			
Medical ☐ Add ☐ Term ☐ Demographic Change ☐ No Change	First Name	MI	Last Name	Suffix
	* Social Security Number	☐ Male ☐ Female	Date of Birth ____________	
Dental ☐ Add ☐ Term ☐ Demographic Change ☐ No Change	Primary Language Spoken: ☐ English ☐ Spanish ☐ Other ____________ Written: ☐ English ☐ Spanish ☐ Other ____________		☐ Spouse ☐ Common-law** ☐ Child ☐ Grandchild ☐ Other Eligible Dependent	
	Disability affecting your ability to communicate or read? ☐ Yes ☐ No			

*required to process

**required documentation to process

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 Scott and White Health Plan d/b/a Baylor Scott & White Health Plan 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. **[☐ I HAVE READ AND ACCEPT THE BELOW AGREEMENT** I understand that the Evidence of Coverage, Explanation of Benefits, and other required documents, notices, and communications may be mailed or transmitted electronically to me. By checking this box and initialing below, I am consenting to the electronic delivery of these communications. If the box is not selected, I will receive paper communications. Consent may be withdrawn at any time by contacting the Scott and White Health Plan d/b/a Baylor Scott & White Health Plan at [800-321-7947]. If consent is withdrawn, paper documents will be provided during the policy benefit period. ___________ Initial]		
Signature	Print Name	Date (MM/DD/YYYY)

Send completed application by one of the following methods:	
Email	[Email: SWHPGroupEnrollment@BSWHealth.org] **[Subject line: Group Name/Group Number/Division]**
Fax	[Fax 254-298-3199]
Mail	[Scott and White Health Plan d/b/a Baylor Scott & White Health Plan MS-A4-126 1206 West Campus Drive Temple, TX 76502]