Baylor Scott & White Insurance Company

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

Mandatory

Group Enrollment PPO Application & Change Form PLAN TYPE_____

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.
- 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) Coverage *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 Baylor Scott & White Insurance Company 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 or become party to a suit to adopt, you may enroll yourself and your dependents, provided that you request enrollment within thirty-one (31) days after the qualifying event.

☐ I decline enrollment in Baylor Scott & White Insurance Company during my initial eligibility period due to the reason listed below. **(employee) OR**

☐ I decline enrollment in Baylor Scott & White Insurance Company 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 (MM/DD/YYYY)	
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 (MM/DD/YYYY)	
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 (MM/DD/YYYY)	
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 (MM/DD/YYYY)	
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 (MM/DD/YYYY)	
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 Baylor Scott & White Insurance Company 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 Certificate of Coverage, Explanation of Benefits, and other required documents, notices, and communications may be mailed or transmitted electronically to me. By completing this enrollment form, I am consenting to the electronic delivery of these communications. Consent may be withdrawn at any time by contacting Baylor Scott & White Insurance Company at [800-321-7947]. If consent is withdrawn, paper documents will be provided during the policy benefit period.]

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	[Baylor Scott & White Insurance Company MS-A4-126 1206 West Campus Drive Temple, TX 76502]