

Group Name	
Top Account Number	
Medical Rider	
Waive New Hire During Open Enrollment	<input type="checkbox"/> Yes <input type="checkbox"/> No

**Mandatory**

## Group Enrollment HMO Application & Change Form

**PLAN TYPE** \_\_\_\_\_

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 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 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 [\[SWHPGroupEnrollment@BSWHealth.org\]](mailto: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.**

<input type="checkbox"/> Open Enrollment <input type="checkbox"/> New Hire <input type="checkbox"/> Current Member	Date of Hire _____	<b>Qualifying Event?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Select the appropriate event and enter event date. Effective date subject to SEP guidelines</i>		<b>Termination/Cancellation Date</b> _____
<input type="checkbox"/> Rehire	Date of Rehire _____	<input type="checkbox"/> Birth/Adoption <b>Proof of Adoption Required</b>	Date of birth/adoption _____	<input type="checkbox"/> Terminate Contract <i>(Enrollee and all dependents)</i> <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Life
<b>Other Changes</b> <input type="checkbox"/> Add Dependent(s) <input type="checkbox"/> Change Plan Option <input type="checkbox"/> Address Update <input type="checkbox"/> Date of Birth <input type="checkbox"/> Name Change <input type="checkbox"/> COBRA Start Date _____		<input type="checkbox"/> Marriage <b>Proof of Marriage Required</b>	Date of marriage _____	<input type="checkbox"/> Terminate Dependent(s) <i>Complete Sections 4, 5, and 6</i>
		<input type="checkbox"/> Loss of Coverage <b>Proof of Loss Required</b>	Date coverage ended _____	<b>Reason for Termination</b> <input type="checkbox"/> Termination of Employment <input type="checkbox"/> Retirement <input type="checkbox"/> Termination of Benefits <input type="checkbox"/> Death: Date _____
		<input type="checkbox"/> Court Order <b>Court Order or Decree Required</b>	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 & White Care Plans d/b/a Baylor Scott & White Care 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 or 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 & White Care Plans d/b/a Baylor Scott & White Care Plan during my initial eligibility period due to the reason listed below. **(employee) (OR)**

☐ I decline enrollment in Scott & White Care Plans d/b/a Baylor Scott & White Care 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		Dental		Life	
Medical <input type="checkbox"/> Add <input type="checkbox"/> Term <input type="checkbox"/> Change <input type="checkbox"/> No Change		<input type="checkbox"/> Add <input type="checkbox"/> Term <input type="checkbox"/> Change <input type="checkbox"/> No Change		<input type="checkbox"/> Add <input type="checkbox"/> 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 <input type="checkbox"/> Active <input type="checkbox"/> Retiree <input type="checkbox"/> COBRA <input type="checkbox"/> Exempt	Marital Status <input type="checkbox"/> Single/Divorced/Widow <input type="checkbox"/> Married <input type="checkbox"/> Other	<input type="checkbox"/> Male <input type="checkbox"/> Female			Date of Birth _____
Primary Spoken Language <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other (please indicate) _____	Written Language <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other (please indicate) _____				
Do you have a disability affecting your ability to communicate or read? <input type="checkbox"/> Yes <input type="checkbox"/> 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.				
<b>Medical</b> <input type="checkbox"/> Add <input type="checkbox"/> Term <input type="checkbox"/> Demographic Change <input type="checkbox"/> No Change	First Name	MI	Last Name	Suffix
	* Social Security Number	<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth _____	
<b>Dental</b> <input type="checkbox"/> Add <input type="checkbox"/> Term <input type="checkbox"/> Demographic Change <input type="checkbox"/> No Change	Primary Language		<input type="checkbox"/> Spouse <input type="checkbox"/> Common-law** <input type="checkbox"/> Child <input type="checkbox"/> Grandchild <input type="checkbox"/> Other Eligible Dependent	
	Spoken: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other _____			
	Written: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other _____			
Disability affecting your ability to communicate or read? <input type="checkbox"/> Yes <input type="checkbox"/> No				
<b>Medical</b> <input type="checkbox"/> Add <input type="checkbox"/> Term <input type="checkbox"/> Demographic Change <input type="checkbox"/> No Change	First Name	MI	Last Name	Suffix
	* Social Security Number	<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth _____	
<b>Dental</b> <input type="checkbox"/> Add <input type="checkbox"/> Term <input type="checkbox"/> Demographic Change <input type="checkbox"/> No Change	Primary Language		<input type="checkbox"/> Spouse <input type="checkbox"/> Common-law** <input type="checkbox"/> Child <input type="checkbox"/> Grandchild <input type="checkbox"/> Other Eligible Dependent	
	Spoken: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other _____			
	Written: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other _____			
Disability affecting your ability to communicate or read? <input type="checkbox"/> Yes <input type="checkbox"/> No				
<b>Medical</b> <input type="checkbox"/> Add <input type="checkbox"/> Term <input type="checkbox"/> Demographic Change <input type="checkbox"/> No Change	First Name	MI	Last Name	Suffix
	* Social Security Number	<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth _____	
<b>Dental</b> <input type="checkbox"/> Add <input type="checkbox"/> Term <input type="checkbox"/> Demographic Change <input type="checkbox"/> No Change	Primary Language		<input type="checkbox"/> Spouse <input type="checkbox"/> Common-law** <input type="checkbox"/> Child <input type="checkbox"/> Grandchild <input type="checkbox"/> Other Eligible Dependent	
	Spoken: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other _____			
	Written: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other _____			
Disability affecting your ability to communicate or read? <input type="checkbox"/> Yes <input type="checkbox"/> No				
<b>Medical</b> <input type="checkbox"/> Add <input type="checkbox"/> Term <input type="checkbox"/> Demographic Change <input type="checkbox"/> No Change	First Name	MI	Last Name	Suffix
	* Social Security Number	<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth _____	
<b>Dental</b> <input type="checkbox"/> Add <input type="checkbox"/> Term <input type="checkbox"/> Demographic Change <input type="checkbox"/> No Change	Primary Language		<input type="checkbox"/> Spouse <input type="checkbox"/> Common-law** <input type="checkbox"/> Child <input type="checkbox"/> Grandchild <input type="checkbox"/> Other Eligible Dependent	
	Spoken: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other _____			
	Written: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other _____			
Disability affecting your ability to communicate or read? <input type="checkbox"/> Yes <input type="checkbox"/> No				
<b>Medical</b> <input type="checkbox"/> Add <input type="checkbox"/> Term <input type="checkbox"/> Demographic Change <input type="checkbox"/> No Change	First Name	MI	Last Name	Suffix
	* Social Security Number	<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth _____	
<b>Dental</b> <input type="checkbox"/> Add <input type="checkbox"/> Term <input type="checkbox"/> Demographic Change <input type="checkbox"/> No Change	Primary Language		<input type="checkbox"/> Spouse <input type="checkbox"/> Common-law** <input type="checkbox"/> Child <input type="checkbox"/> Grandchild <input type="checkbox"/> Other Eligible Dependent	
	Spoken: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other _____			
	Written: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other _____			
Disability affecting your ability to communicate or read? <input type="checkbox"/> Yes <input type="checkbox"/> 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 & White Care Plans d/b/a Baylor Scott & White Care 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 & White Care Plans d/b/a Baylor Scott & White Care 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)
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**Send completed application by one of the following methods:**

<b>Email</b>	[Email: <a href="mailto:SWHPGroupEnrollment@BSWHealth.org">SWHPGroupEnrollment@BSWHealth.org</a> [Subject line: Group Name/Group Number/Division]
<b>Fax</b>	[Fax 254-298-3199]
<b>Mail</b>	[Scott & White Care Plans d/b/a Baylor Scott & White Care Plan MS-A4-126 1206 West Campus Drive Temple, TX 76502]