

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 _____

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.				
<ul style="list-style-type: none"> 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.				
<input type="checkbox"/> Open Enrollment <input type="checkbox"/> New Hire <input type="checkbox"/> Current Member	Date of Hire __/__/__	Qualifying Event? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Select the appropriate event and enter event date. Effective date subject to SEP guidelines</i>		Termination/Cancellation Date __/__/__
<input type="checkbox"/> Rehire	Date of Rehire __/__/__	<input type="checkbox"/> Birth/Adoption Proof of Adoption Required	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
Other Changes <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 Proof of Marriage Required	Date of marriage __/__/__	<input type="checkbox"/> Terminate Dependent(s) <i>Complete Sections 4, 5, and 6</i>
		<input type="checkbox"/> Loss of Coverage Proof of Loss Required	Date coverage ended __/__/__	Reason for Termination <input type="checkbox"/> Termination of Employment <input type="checkbox"/> Retirement
		<input type="checkbox"/> Court Order Court Order or Decree Required	Date of order __/__/__	<input type="checkbox"/> Termination of Benefits <input type="checkbox"/> Death: Date __/__/__

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 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 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 _____ Policy number and coverage start date _/_/___
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SECTION 4: EMPLOYEE INFORMATION – All information in this section is necessary for accurate and timely processing.

Coverage Selection Medical <input type="checkbox"/> Add <input type="checkbox"/> Term <input type="checkbox"/> Change <input type="checkbox"/> No Change		Dental <input type="checkbox"/> Add <input type="checkbox"/> Term <input type="checkbox"/> Change <input type="checkbox"/> No Change		Life <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.

Medical <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 _/_/___	
Dental <input type="checkbox"/> Add <input type="checkbox"/> Term <input type="checkbox"/> Demographic Change <input type="checkbox"/> No Change	Primary Language 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 _____		<input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner* <input type="checkbox"/> Child <input type="checkbox"/> Grand Child <input type="checkbox"/> Other Eligible Dependent	
	Disability affecting your ability to communicate or read? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Medical <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 _/_/___	
Dental <input type="checkbox"/> Add <input type="checkbox"/> Term <input type="checkbox"/> Demographic Change <input type="checkbox"/> No Change	Primary Language 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 _____		<input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner* <input type="checkbox"/> Child <input type="checkbox"/> Grand Child <input type="checkbox"/> Other Eligible Dependent	
	Disability affecting your ability to communicate or read? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Medical <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 _/_/___	
Dental <input type="checkbox"/> Add <input type="checkbox"/> Term <input type="checkbox"/> Demographic Change <input type="checkbox"/> No Change	Primary Language 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 _____		<input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner* <input type="checkbox"/> Child <input type="checkbox"/> Grand Child <input type="checkbox"/> Other Eligible Dependent	
	Disability affecting your ability to communicate or read? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Medical <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 _/_/___	
Dental <input type="checkbox"/> Add <input type="checkbox"/> Term <input type="checkbox"/> Demographic Change <input type="checkbox"/> No Change	Primary Language 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 _____		<input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner* <input type="checkbox"/> Child <input type="checkbox"/> Grand Child <input type="checkbox"/> Other Eligible Dependent	
	Disability affecting your ability to communicate or read? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Medical <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 _/_/___	
Dental <input type="checkbox"/> Add <input type="checkbox"/> Term <input type="checkbox"/> Demographic Change <input type="checkbox"/> No Change	Primary Language 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 _____		<input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner* <input type="checkbox"/> Child <input type="checkbox"/> Grand Child <input type="checkbox"/> Other Eligible Dependent	
	Disability affecting your ability to communicate or read? <input type="checkbox"/> Yes <input type="checkbox"/> No			

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)
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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]