

INSTRUCTIONS

- 1. You, the employee, should complete this enrollment form in your own handwriting.**
You are solely responsible for its accuracy and completeness.
- 2. All questions must be answered in full or the enrollment form may be returned to you resulting in a delay in processing.**
- 3. Print clearly using black ink. Typed enrollment forms will not be accepted.**

2. MEDICAL COVERAGE

No Deductible Plan Select 001 HMO

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 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.

Plan Name	Plan Name
<input type="checkbox"/> Select 3000-80	<input type="checkbox"/> Select 3000-80 HSA
<input type="checkbox"/> Select 5000-80	<input type="checkbox"/> Select 5000-80 HSA
<input type="checkbox"/> Select 2000-100	<input type="checkbox"/> Select 3000-100 HSA
<input type="checkbox"/> Select 5000-100	<input type="checkbox"/> Select 6450-100 HSA
<input type="checkbox"/> Select 6600-100 Premier	<input type="checkbox"/> Select Premier Copay
<input type="checkbox"/> Select 6600-100 Standard	<input type="checkbox"/> Select Standard Copay
<input type="checkbox"/> Custom Plan	<input type="checkbox"/> Custom Plan

2. EMPLOYEE INFORMATION - Must be completed by employee.

- New Group Enrollment Late Enrollment New Hire COBRA effective date: _____
 Family Addition Re-Enrollment Change of Coverage Annual Open Enrollment State Continuation

LAST NAME	FIRST NAME	MI	MARITAL STATUS <input type="checkbox"/> Single <input type="checkbox"/> Married	SOCIAL SECURITY NO.
HOME ADDRESS (P.O. Box not acceptable unless rural P.O. Box)			APT. NO.	HOME PHONE NO.
CITY	STATE	ZIP CODE		EMPLOYEE/SPOUSE'S/DOMESTIC PARTNER'S MAIDEN NAME
GROUP NAME	OCCUPATION / JOB TITLE	FULL-TIME DATE OF HIRE		SPOUSE'S/DOMESTIC PARTNER'S SOCIAL SECURITY NO.
BUSINESS PHONE NO.	E-MAIL			

Please Note: If any dependent has a different address, please write the dependent's name, relationship to the employee, and address on a separate sheet and attach to this enrollment form.

3. EMPLOYEE / DEPENDENT AND DOMESTIC PARTNER INFORMATION - List yourself and only those eligible dependents who are applying for coverage. An eligible "dependent" is an employee's lawful spouse as recognized under Texas Law, or domestic partner; children or step-children who are under age 26; adopted children under age 26, including a child for whom the Eligible Employee is a party in a suit to adopt, children, who have not yet reached age 26, for whom an Eligible Employee is subject to a court ordered medical support order; Eligible Employee's or Spouse's own children, of any age, who, prior to the limiting age, become incapable of self-support due to continuing mental retardation or physical handicap and who are chiefly dependent on the Eligible Employee; Eligible Employee's or Spouse's own children, of any age, who are: (i) medically certified as disabled; and (ii) dependent on the parent; or unmarried grandchildren who are under age 26 and are dependents for federal income tax purposes at the time of this enrollment form.

If family addition is spouse, date of marriage: _____

If family addition is domestic partner, attach affidavit.

Relation	Sex	Last Name	First Name	M.I.	User Of Tobacco Products*?	Height	Weight	Disabled?	Primary Language	Disability affecting ability to communicate or read?	Birth Date Month Day Year	Social Security Number
Employee	<input type="checkbox"/> Male <input type="checkbox"/> Female				<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No		
Spouse / Domestic Partner	<input type="checkbox"/> Male <input type="checkbox"/> Female				<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No		
	<input type="checkbox"/> Male <input type="checkbox"/> Female				<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No		
	<input type="checkbox"/> Male <input type="checkbox"/> Female				<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No		
	<input type="checkbox"/> Male <input type="checkbox"/> Female				<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No		

*Check Yes if you or the dependent use or have used tobacco an average of four or more times per week within the past six months, excluding religious or ceremonial uses.
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"As applicable, enrollee may select an obstetrician or gynecologist 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 or primary care provider.

4. COVERAGE DECLINATION - To be completed if any coverage is declined or refused by an eligible employee and / or their eligible family members.

A. Medical Group Coverage Declined (please check box or write in requested information)

	Myself	Spouse / Domestic Partner	Dependent(s)
Covered by spouse/domestic partner's group coverage - List Insurance Company Name:			
List ID Number			
Enrolled in any other Insurance Co. Plan - List Insurance Company Name:			
List ID Number			
Medicare			
Covered by TRICARE			
Other (Explain):			

I acknowledge the available coverage has been explained to me by the Group and know I have the right to enroll in coverage. I have been given the chance to enroll in this coverage and I have decided not to enroll myself and / or my dependent(s), if any. I have made this decision voluntarily and no one has influenced me or pressured me to decline coverage. By declining this group medical coverage (unless employee and / or dependents have group medical coverage elsewhere*), I acknowledge if I wish to enroll at a later date, my dependent(s) and I will have to wait until the Group's next annual open enrollment period.

x _____

Signature if declining coverage for employee / dependent(s) **Date (Month / Day / Year)**

* If you are declining coverage for yourself or your dependents (including your spouse/domestic partner) because of other health Insurance coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards you or your dependents' other coverage). However, you must request enrollment within 31 days of the date you or your dependents' other coverage ends (or within 31 days of the date the employer stops contributing toward the other coverage). In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, or you become a party in a suit for the adoption of a child, (a "qualifying event"), you may be able to enroll yourself and your dependents at that time. However, you must request enrollment within 31 days of the qualifying event. Please refer to the Eligibility section of your Evidence of Coverage for a complete list of exceptions to the definition of a "late enrollee."

5. HEALTH QUESTIONNAIRE FOR GROUPS ENROLLING 51 OR MORE EMPLOYEES

1. Within the last 10 years, has any person listed on this Application, had any signs or symptoms, had a consultation for, received advice for, sought diagnosis or treatment for, had treatment recommended for, received treatment (including medication) for, or been hospitalized for any of the following conditions: Cardiovascular disease or heart disorders, strokes, disorders of the kidney, stomach, intestines or liver; mental or nervous..... conditions; central nervous system disorders, diabetes; any disorders of the lungs or respiratory system or cancer?.....	Yes	No
2. Within the last 10 years, has any person listed on this application been medically diagnosed with an immune deficiency disorder (AIDS), AIDS-related complex or tested positive for HIV?	<input type="checkbox"/>	<input type="checkbox"/>
3. During the last 24 months, has any person listed on this Application had surgery or been confined in any hospital, sanitarium, convalescent facility or specialized care facility or had medical expenses more than \$ 5,000?	<input type="checkbox"/>	<input type="checkbox"/>
4. Is any person listed on this Application:		
a. Currently under treatment, receiving counseling or taking medicine for any condition or disease?	<input type="checkbox"/>	<input type="checkbox"/>
b. Currently pregnant or is any male expecting a child With anyone, whether listed on this Application or not?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, due date (Month, Day, Year) _____		
c. A user of tobacco products within the last 2 years?	<input type="checkbox"/>	<input type="checkbox"/>

5. HEALTH QUESTIONNAIRE FOR GROUPS ENROLLING 51 OR MORE EMPLOYEES (Continued)

If you answer "YES" to any of the above questions, complete the following: (Attach additional sheets if necessary).

Name of patient: _____
 Condition/illness: _____
 Dates of treatment: From _____ Through _____
 Treatment rendered: _____
 Still under treatment? Yes No
 Medication and dosage taken: _____
 Date: From _____ Through _____
 Treating providers, name/address: _____

Name of patient: _____
 Condition/illness: _____
 Dates of treatment: From _____ Through _____
 Treatment rendered: _____
 Still under treatment? Yes No
 Medication and dosage taken: _____
 Date: From _____ Through _____
 Treating physicians, name/address: _____

6. OTHER MEDICAL COVERAGE FOR ALL ENROLLING EMPLOYEES AND DEPENDENTS (All questions must be answered.)

	Yes	No
1. Do any persons on this enrollment form intend to continue other Group coverage if this enrollment form is accepted?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, name of person: _____		
Insurance Co. _____ Policy No. _____		
2. Is any person applying for coverage eligible for Medicare?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, Name: _____		

7. AUTHORIZATION/DISCLOSURE STATEMENT (The following Authorization is to be signed by each employee applying for coverage.)

I agree: All information on this form is correct and true. I understand that it is the basis on which coverage is issued under the plan. I further authorize the Group to deduct my contribution, if any, from my earnings towards the cost of this plan. I certify that I usually work 30 hours per week for this Group.

I understand that my Group's Application will determine coverage and that there is no coverage unless and until both my Enrollment form and the Group's Applications have been accepted and approved by MHHP.

I represent that I have read this and that even if this is approved by MHHP, any fraud or intentional misrepresentation of material fact on this, regarding me or my spouse/domestic partner, as applicable, may result in future claims being denied, or my coverage and/or my spouse's/domestic partner's coverage under the Group's Plan being rescinded or re-evaluated retroactive to my effective date for eligibility and rating purposes.

Arbitration Agreement: I understand any dispute between MHHP and me may be subject to binding arbitration. The arbitration will be conducted pursuant to the applicable commercial rules of the American Arbitration Association and applicable Texas statutes governing such arbitration. The arbitration will be binding only if both parties agree and the arbitration will occur in the county where the Evidence of Coverage holder or, if applicable, beneficiary resides. By signing this Application, I am not agreeing to binding arbitration. If I am enrolling in a Group-sponsored plan that is subject to ERISA, I understand that any dispute involving an adverse benefit decision may be submitted to voluntary binding arbitration only after the ERISA appeal process is completed. In addition, I understand that I have appeal rights under state law, under Texas Insurance Code Chapter 4201 and 28 Texas Administrative Code Chapter 19.

This was completed by someone other than me. I, the enrollee, represent I have read all the information provided as responses in this and warrant to MHHP such information is true, complete and accurate as of the current date, and if I had completed this on my own, the information provided on the enrollment form would remain the same.

I completed this. I represent to MHHP I have read all the information provided in response to the questions on this and I represent to MHHP such information is true, complete and accurate as of the current date.

I, acknowledge I have read and understand this in its entirety.

SIGNATURE OF EMPLOYEE (Required)	TODAY'S DATE (Required)
X	

SIGNATURE OF EMPLOYEE'S SPOUSE/ DOMESTIC PARTNER (If applying for coverage)	TODAY'S DATE (Required)
X	

Incomplete Enrollment Forms will be mailed back to you for completion. This may delay the effective date of your coverage.

I UNDERSTAND THAT I AM ENROLLING IN HEALTH MAINTENANCE (HMO) COVERAGE, NOT PPO HEALTH COVERAGE.

Coverage is underwritten by Memorial Hermann Health Plan, Inc. The Memorial Hermann Health Plan, Inc. logo is a registered trademark of Memorial Hermann Health System.