MEMORIAL HERMANN
Health Insurance Co

Medical Coverage underwritten by Memorial Hermann Health Insurance Company

EMPLOYEE ENROLLMENT

Memorial Hermann Health Insurance Company ("MHHIC") GROUP NUMBER
(If existing MHHIC Group)

____

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.**

1. COVERAGE MHHIC SELECT PLUS

	Plan Name		Plan Name		Plan Name		Plan Name
☐	Select 2500-70	☐	Select 3000-80	☐	Select 6600-100 Premier	☐	Select 1500-100 HSA
☐	Select 5000-70	☐	Select 5000-80	☐	Select 6600-100 Standard	☐	Select 2000-100 HSA
☐	Select 250-80	☐	Select 500-85	☐	Select Premier Copay	☐	Select 3000-100 HSA
☐	Select 500-80	☐	Select 1500-100	☐	Select Standard Copay	☐	Select 5000-100 HSA
☐	Select 1000-80	☐	Select 2000-100	☐	Select 3000-50 HSA	☐	Select 6450-100 HSA
☐	Select 1500-80	☐	Select 3000-100	☐	Select 5000-50 HSA	☐	Custom Plan
☐	Select 2000-80	☐	Select 5000-100	☐	Select 3000-80 HSA	☐	Custom Plan
☐	Select 2500-80	☐	Select 5000-80 HSA				

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 ☐Single ☐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 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; or unmarried grandchildren who are under age 26 and are dependents for federal income tax purposes at the time of enrollment form.

If family addition is spouse, date of marriage: |______________________|

MHHIC may require proof that a domestic partnership exists to ensure eligibility requirements are met.

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	☐ Male ☐ Female				☐Yes ☐No			☐Yes ☐No		☐Yes ☐No		
Spouse /Domestic Partner	☐ Male ☐ Female				☐Yes ☐No			☐Yes ☐No		☐Yes ☐No		
	☐ Male ☐ Female				☐Yes ☐No			☐Yes ☐No		☐Yes ☐No		
	☐ Male ☐ Female				☐Yes ☐No			☐Yes ☐No		☐Yes ☐No		
	☐ Male ☐ Female				☐Yes ☐No			☐Yes ☐No		☐Yes ☐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.

As applicable, enrollee may select an obstetrician or gynecologist to provide the enrollee with health care services that are within the scope of the professional specialty practice of a properly credentialed obstetrician or gynecologist. 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	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 (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 a qualifying event.

5. HEALTH QUESTIONNAIRE FOR GROUPS ENROLLING 51 OR MORE EMPLOYEES

	Yes	No
1. Within the last 10 years, has any person listed on this Enrollment Form, 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?....................	☐	☐
2. Within the last 10 years, has any person listed on this Enrollment Form been medically diagnosed with an immune deficiency disorder (AIDS), AIDS-related complex or tested positive for HIV?	☐	☐
3. During the last 24 months, has any person listed on this Enrollment Form had surgery or been confined in any hospital, sanitarium, convalescent facility or specialized care facility or had medical expenses more than $ 5,000?	☐	☐
4. Is any person listed on this Enrollment Form:		
a. Currently under treatment, receiving counseling or taking medicine for any condition or disease?....................	☐	☐
b. Currently pregnant or is any male expecting a child with anyone, whether listed on this Enrollment Form or not? .... If yes, due date (Month, Day, Year) ______________________	☐	☐
c. A user of tobacco products within the last 2 years?	☐	☐

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: ______	Name of patient: ______
Condition/illness: ______	Condition/illness: ______
Dates of treatment: From ______ Through ______	Dates of treatment: From ______ Through ______
Treatment rendered: ______	Treatment rendered: ______
Still under treatment? ☐ Yes ☐ No	Still under treatment? ☐ Yes ☐ No
Medication and dosage taken: ______	Medication and dosage taken: ______
Date: From ______ Through ______	Date: From ______ Through ______
Treating providers, name/address: ______	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?	☐	☐
If yes, name of person: ______		
Insurance Co. ______ Policy No. ______		
2. Is any person applying for coverage eligible for Medicare?	☐	☐
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 my Group to deduct my contribution, if any, from my earnings towards the cost of this plan. I certify that I am working at the Group's place of business in permanent employment for at least 30 hours per week.

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 Application have been accepted and approved by MHHIC.

I represent that I have read this and that even if this is approved by MHHIC, any misstatements or omissions 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 Group's Plan being rescinded or re-evaluated retroactive to my effective date for eligibility and/rating purposes.

I am applying for Participating Provider Plan coverage: I understand that I am responsible for a greater portion of my medical costs when I use a nonparticipating provider.

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy or pharmacy benefit manager, medical facility, or other health care provider ("My Providers") that has provided payment, treatment or services to me or any of my dependents, who are also applying for coverage, to disclose entire medical records, prescription history, medications prescribed and any other protected health information concerning me or any of my dependents, who are also applying for coverage, to Memorial Hermann Health Insurance Company (MHHIC) or its designated agent. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

By signing below, I acknowledge any agreements made to restrict protected health information do not apply to this enrollment form and I instruct any physician, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose entire medical records without restriction.

This protected health information is to be disclosed under this Authorization so MHHIC may: 1) underwrite my enrollment form for coverage, make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities that relate to any coverage I have or have applied for with MHHIC.

This Authorization remains in force for 36 months following the date of signature below, and a copy of this Authorization is as valid as the original. I understand I have the right to revoke this Authorization in writing, at any time, by providing written notification to MHHIC. I understand that a revocation is not effective to the extent that any of my providers have already relied on this Authorization to disclose information about me or any of my dependents who are also applying for coverage or to the extent that MHHIC has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand any information disclosed pursuant to this Authorization is no longer covered by federal rules governing privacy and confidentiality of health information, but it will not be redisclosed by MHHIC except as authorized by me or as required by law.

I understand my providers may not refuse to provide treatment or payment for health care services if I refuse to sign this Authorization. I further understand if I refuse to sign this Authorization to release complete medical records, MHHIC may not be able to process my enrollment form, or, if coverage has been issued, may not be able to make any benefit payments. I understand any authorized representative, MHHIC designated agent or I may receive a copy of this authorization upon request.

AUTHORIZATION/DISCLOSURE STATEMENT *(Continued)*

I understand my Group's Application will determine coverage in force and that there is no coverage unless and until both my Enrollment Form and the Group's Application have been accepted and approved by MHHIC.

Arbitration Agreement: I understand any dispute between MHHIC 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 Enrollment Form, 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.

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

☐ I completed this. I, represent to MHHIC I have read all the information provided in response to the questions on this and I represent to MHHIC 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.

Insurance coverage is underwritten by Memorial Hermann Health Insurance Company. The Memorial Hermann Health Insurance Company logo is a registered trademark of Memorial Hermann Health System.