MEMORIAL HERMANN Health Plan

Medical Coverage underwritten by Memorial Hermann Health Plan, Inc.

Your Individual Application Kit is Enclosed

Thank You for Applying with Memorial Hermann Health Plan, Inc. ("MHHP").

Please note:

- **Tobacco users pay an additional premium. Misstatements of tobacco usage status on the application enrollment form shall not be used to void, cancel or nonrenew this coverage. MHHP may increase the premium for this plan to the appropriate level if MHHP determines that you made a misstatement of tobacco usage status on this application.** For family applications, if any family member who is to be insured smokes or uses tobacco ("rated person(s)"), an additional premium will be applied to the rated person(s).

- **Coverage is not guaranteed until approved in writing by MHHP. Do not cancel your current insurance coverage until you have been notified of approval by MHHP and your MHHP coverage is effective.**

Instructions

Do not complete this application until you have read the current product brochure.

Please follow the instructions below to allow for better processing of your application.

- For your own protection, **you, the applicant,** must complete this application. You are solely responsible for its accuracy and completeness.
- All information must be stated accurately.
- All questions must be answered in full or the application may be returned to you resulting in a delay in processing.
- For additional information or explanations attach extra sheets if necessary. **All attachments must be signed and dated.**
- Print clearly using blue or black ink (no correction fluid, please).
- This application must be received by MHHP Medical Underwriting within thirty (30) days from the signature date.
- MHHP Elect Plans are available only in areas where the MHHP Select Network exists. Please see Provider Directories for more details.
- Even if this application is approved, any intentional misstatements or omissions may result in future claims being denied and the plan being rescinded.
- Your insurance will become effective only if this application is approved as applied for, the appropriate premium is received, and other specific conditions are met. **(See details under Section H – Significant Terms, Conditions and Authorizations).**
- Please return this application and your choice of payment method to your agent, or mail to the address identified in the Mailing Address section.
- **If you make changes while completing this form or cross out something you wrote, be sure to initial those changes.**

Instructions (continued)

- If any corrections are needed or the form is incomplete, the application may have to be returned to you, or we may try to contact you to obtain the necessary information. In that case, we will record your information on a form that will be attached to the application.
- Your effective date of coverage will be consistent with federal law, based on the date of receipt of your signed application.

Instructions (continued)

Most Common Causes for Delay in Underwriting

- Missing, incomplete, or inaccurate information such as:

— Spouse's or Domestic Partner's Social Security Number

— Dependent's Social Security Number

— Date of birth

— Physician address, phone number and fax number

- Incomplete or illegible information such as the mailing address not including city, state and ZIP code.
- Application not signed and dated by the applicant, spouse, domestic partner, and/or all dependents over age 18 (if applicable).
- Agent portion of application not completed, signed, or dated with a date on or after applicant's signature date (if applicable).
- Additional documentation or information required.

Mailing Address

- **Applicant:** Please return this application to your agent (if applicable) or email to

insidesales@memorialhermann.org or mail to
Memorial Hermann Health Plan, Inc.
Attn: Inside Sales
929 Gessner, Suite 1500
Houston, TX 77024

- **Agent:** Please email this application to:

insidesales@memorialhermann.org

MEMORIAL HERMANN Health Plan

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Memorial Hermann Health Plan, Inc.

Texas Individual Application

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.

Please complete in blue or black ink only.

Section A – Coverage Information

Application Type:

☐ New Coverage ☐ Add dependent(s) ☐ Change coverage ☐ Child Only (Please complete section J)

Policy No. _____ Policy No. _____

Has the Applicant been without health coverage for at least 2 months prior to the requested Effective Date? ☐ Yes ☐ No

Effective date: Effective date will be the date that coverage is required by federal law, which is dependent on the date of your application and reason for your application. If you wish to request a later effective date, please indicate the month and year you would like coverage to begin.

Please choose the month and year you would like your coverage to start: _____ MM/01/YY

Section B – Applicant Information

Last Name	First Name	M.I.	Social Security Number*
Home Address (Residence address required; P.O. Box not acceptable)			
City	State		Zip
Marital Status ☐ Single ☐ Married ☐ Domestic Partner/Common Law	Sex ☐ M ☐ F	Age	Date of Birth (MM/DD/YY) / /
Daytime Phone Number ( )	Evening Phone Number ( )	If possible, do you want E-mail notification? ☐ Yes ☐ No E-Mail*:	
Mailing Address (If different from above) (P.O. Box or Personal Mail Box No.)			
In care of (if applicable)			
City	State	Zip Code	Fax No. ( )
Primary Language	Disability affecting ability to communicate or read? ☐ Yes ☐ No		

* This information is used for internal purposes or required regulatory reporting only.

Section C – Spouse or Domestic Partner to be Covered Information (All fields required.) If family addition is domestic partner, please attach affidavit.

Last Name	First Name	M.I.	Relationship Spouse/Domestic Partner

Social Security Number*	Sex ☐ M ☐ F	Age	Date of Birth (MM/DD/YY) / /

Primary Language	Disability affecting ability to communicate or read? ☐ Yes ☐ No

Section D – Child Dependents to be Covered Information (All fields required. Attach a separate sheet if necessary.)

Dependent information must be completed for all child dependents to be covered under this coverage. (List all dependents beginning with the youngest.)

First, M.I. (last name if different)	Social Security Number*	Primary Language	Disability affecting ability to communicate or read?	Sex	Age	Date of Birth (MM/DD/YY)
			☐ Yes ☐ No	☐ M ☐ F		/ /
			☐ Yes ☐ No	☐ M ☐ F		/ /
			☐ Yes ☐ No	☐ M ☐ F		/ /
			☐ Yes ☐ No	☐ M ☐ F		/ /
			☐ Yes ☐ No	☐ M ☐ F		/ /

* This information is used for internal purposes or required regulatory reporting only.
As applicable, applicant may select an obstetrician or gynecologist as set forth in the Texas Insurance Code Chapter 1451, Subchapter F. Applicant may designate the selection here:

_____ _____

_____ _____

_____ _____

Applicant 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.

Section E – Medical Coverage Selection

No Deductible Plan

☐ [Elect Gold 001 HMO]

Choice of MHHP Individual Coverage (Choose one plan only)

☐ Elect Gold 1000 HMO ☐ Elect Silver 4500 HMO ☐ Elect Bronze 6550 HSA HMO

☐ Elect Gold 2500 HMO ☐ Elect Bronze 6850 HMO

Section F – Payment Options

1. INITIAL PREMIUM

The premium amount may change during the underwriting process as a result of an applicant being placed into a higher rating tier, which will cause your initial and ongoing premium payment amounts to be at the higher premium rate. If you are approved for coverage, initial premium will be required before your coverage begins. MHHP will notify you of the required premium.

☐ Check Enclosed (If paying by check, make the check payable to Memorial Hermann Health Plan, Inc.)

☐ Credit Card (complete Section 2C) Business checks are not acceptable.

Payment:

Name on Checking Account (PRINT)	Bank Routing No.	Checking Account No.	Total Amount:	Check No.
			$	

2. METHOD

☐ **A. Home -** Monthly bills will be sent to your mailing address unless a separate billing address is listed below.

Name	Address (street and P.O. Box if applicable)	City	State	Zip

☐ **B. Automatic Bank Draft (automatic monthly premium withdrawals) –** By providing your check information, you authorize us to electronically debit your bank account. Subsequent premium amounts will be debited from your checking account on or about the first of the month.

I authorize MHHP to initiate premium deductions from the checking account indicated and the designated financial institution to debit the same account. I understand that this authorization is in effect until I notify MHHP in writing that I no longer desire this service, allowing them reasonable time to act upon my notification. I understand MHHP and my financial institution have the right to discontinue the withdrawals if they wish to do so.

Account holder's name (please print)	Account holder's signature (if other than the applicant)
X	X

Name on Checking Account (PRINT)

Bank Routing No. | Checking Account No.

Bank Routing No. | Bank Account No.

☐ **C. If Paying by Credit Card**

Charge my credit card for check one:

☐ 1st payment ☐ 1st and subsequent payments

If applicant is using the credit card of another cardholder he/she has the cardholder's authorization to use this card and, and any charges accruing to it.

By signing this form, applicant represents and warrants that if not, that he/she will take full responsibility for this payment

Credit card information —

Cardholder's Name (as shown on the credit card):

Billing Zip Code:

_____

Type of Credit Card: ☐ VISA ☐ MasterCard ☐ Other

Credit Card Number:

Exp. Date (MM/YY):

_____

Authorization: I authorize MHHP to charge the credit card

Indicated Dollar Amount of Premium Payments.

Applicant's Signature:

X_____

_____

Section G – Tobacco Usage

1. Within the past six months, has anyone applying for coverage on this application used tobacco regularly (four or more times per week on average, excluding religious or ceremonial uses)? ☐ Yes ☐ No

2. If yes, please indicate which individuals use tobacco regularly.

Section H – Significant Terms, Conditions and Authorizations (TERMS)

All applicants age 18 and over must personally read, agree to, and sign the following. If an applicant does not read English, the translator must sign and submit the Statement of Accountability, Section J, for translating this entire application.

Effective Date

If you currently have health coverage, we strongly recommend that you maintain your current coverage, and allow us to assign your effective date FOLLOWING APPROVAL.

X_____ _____
Initials of Applicant Date

Billing Date

MHHP premiums are due on the 1st of each month.

Agreement (All applicants)

I, the undersigned, agree to the following:

1. I agree I have no coverage under this application until I am notified in writing by MHHP that my application is approved.
2. MINOR CHILDREN: I represent that I have made such investigations as are necessary to assure the truth and accuracy of all statements made in this application regarding minor children.
3. CONCERNING DEPENDENTS AGE 18 AND OVER:

   I represent that my dependents age 18 and over (1) have read this application and have provided such full and accurate information necessary to complete this application, (2) I have discussed all provisions of this application, and agree that all information contained in this application regarding them is complete and accurate.
4. This application will become part of the agreement between MHHP and myself.
5. I certify that my employer will not, directly or indirectly, contribute to any premium payments for this policy, including through a health reimbursement arrangement (HRA) or Internal Revenue Code 125 Plan (cafeteria plan).
6. My MHHP agent may receive copies of any correspondence about my medical history when correspondence is required.

☐ If you authorize MHHP to provide your agent copies of any correspondence regarding your medical history, during this application process, please check this box.

☐ By checking this box, you agree that by typing your name, you are signing this agreement electronically and agree to its terms and conditions. You also agree that your electronic signature is the legal equivalent of your manual signature on this agreement.

SIGN HERE		
	Signature of Applicant* X	Date
	Signature of Spouse or Domestic Partner (if to be covered) X	Date
	Signature of Dependent Age 18 or Older (if to be covered) X	Date
	Signature of Dependent Age 18 or Older (if to be covered) X	Date

* (or Custodial Parent's or Guardian's signature if applicant is under age 18)

Section I – Agent Certification

To be completed by your MHHP-Appointed Agent

Are you aware of any information not disclosed on this application relating to the person listed on this application which might have a bearing on the risk? ☐ Yes ☐ No

Did you see the applicant (and spouse or domestic partner, if applying) at the time this application was executed? ☐ Yes ☐ No

If no, please explain: _____

By signing below, I verify that this application was completed by the applicant unless the Statement of Accountability (Section L) was completed.

Agent Signature X			Date
Agent Name (please print)		Agent Email Address	
Agent No.	Agency No.	Agent Phone No.	Agent Fax No.

If a legal representative signs on behalf of the applicant or spouse /domestic partner, a copy of the legal representative's authority must be attached to the application.

Section J – Statement of Accountability To be completed when the applicant cannot complete the application.

I, _____, personally read and completed this Individual Application for the applicant named below:

☐ Applicant does not read English ☐ Applicant does not write English

☐ Applicant does not speak English ☐ Applicant is a child

☐ Other (explain): _____

I translated the contents of this form and to the best of my knowledge, obtained and listed all the requested personal and medical history disclosed by: _____

I also translated and fully explained the "Significant Terms, Conditions, and Authorizations (TERMS) (Section H)."

Signature of Translator or Legal Guardian (if applicant is a Child X	Today's Date (Required)

Conditional Receipt – To be completed by the agent and given to the applicant.

Received from _____

$ _____ as a nonrefundable application fee payable to MHHP.

$ _____as a premium, payable to MHHP.

Dated this _____ day of _____ , 20_____.

Agent acknowledges receipt of money and delivery of Conditional Receipt.

Signature of Agent X	Agent I.D. Number

Notice of Information Practices

If you apply for or are covered by a MHHP health care plan, MHHP may collect personal information about you in order to evaluate your application or to administer benefits. This information is normally limited to the condition of your health. MHHP may also provide information to a health care provider in order to verify benefits. Upon your request, MHHP will provide details of the nature of personal information that may be collected, the circumstances under which it may be disclosed without authorization, and your right to access and correct that information if you believe it to be inaccurate. MHHP can choose to furnish the medical record information either directly to you or to a medical professional designated by you.

As of the Effective Date indicated above on page one of this Application, MHHP hereby agrees to issue coverage to the above named Applicant, pursuant to the terms and conditions of the attached Individual Policy. This is the signature page for the Individual Policy.

_____

Company Officer Name, Title