GROUP NUMBER (If existing MHHP group) _____

Memorial Hermann Health Plan, Inc.
Memorial Hermann Health Solutions, Inc.
Memorial Hermann Health Insurance Company
Memorial Hermann Commercial Health Plan, Inc.

EMPLOYEE ENROLLMENT FORM

Memorial Hermann Health Solutions, Inc. ("MHHSI")
Medical Coverage administered by Memorial Hermann Health Solutions, Inc.

1. ENROLLMENT SELECTION

☐ New Group Enrollment ☐ Late Enrollment ☐ New Hire ☐ Annual open Enrollment

☐ Family Addition ☐ Re – Enrollment ☐ Change of Coverage ☐ Change of Address

☐ COBRA effective date: _____ Original effective date:_____ COBRA Reason:_____

2. EMPLOYEE INFORMATION - Must be completed by employee.

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 MAIDEN NAME
GROUP NAME	OCCUPATION/ JOB TITLE	FULL-TIME DATE OF HITE		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 applicable 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 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?*	Disabled	Primary Language	Disability affecting ability to communicate or read	Birth Date xx/xx/xxxx	SSN**	PCP Name and PCP Number (Only for HMO Coverage)
Employee	☐ M ☐ F				☐ Yes ☐ No	☐ Yes ☐ No		☐ Yes ☐ No			
Spouse/ Domestic Partner	☐ M ☐ F				☐ Yes ☐ No	☐ Yes ☐ No		☐ Yes ☐ No			
	☐ M ☐ F				☐ Yes ☐ No	☐ Yes ☐ No		☐ Yes ☐ No			
	☐ M ☐ F				☐ Yes ☐ No	☐ Yes ☐ No		☐ Yes ☐ No			
	☐ M ☐ F				☐ 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.*

***If you do not provide the SSN for any dependent child (up to 18 years old), complete the Social Security Attestation Form.*

As applicable, an Enrollee may select an obstetrician or gynecologist to serve as a Primary Care Physician (for HMO Coverage only). The Enrollee may designate the selection here:

_____

_____

An 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. MEDICAL COVERAGE SELECTION

Hybrid Plan Small Group (group size 2-50):

HMO Plan:_____

PPO Plan: _____

5. 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 Member ID Number			
Enrolled in any other Insurance Co. Plan:			
List Insurance Company Name			
List Member ID Number			
Covered by Medicare			
Covered by TRICARE			
Other (Explain):			

I acknowledge the available coverage has been explained to me by the Employer and I 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 Employer'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 the qualifying event.

6. OTHER MEDICAL COVERAGE FOR ALL PERSONS ENROLLING

1. Do any persons on this Enrollment Form intend to continue other Group coverage if this Enrollment Form is accepted? …. ☐ Yes ☐ No
   If yes, name of person: _____
   Insurance Co: _____ Policy No. _____

2. Is any person applying for coverage eligible for Medicare? ……. ☐ Yes ☐ No
   If yes, Name: _____

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 Employer to deduct my contribution, if any, from my earnings towards the cost of this plan. I certify that I am working at the Employer's place of business in permanent employment for at least 30 hours per week.

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

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

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

I acknowledge I have read and understand this Enrollment Form in its entirety.

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

SIGNATURE OF EMPLOYEE'S SPOUSE'S/DOMESTIC PARTNERS (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.

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