MEMORIAL HERMANN Health Plan
COMMERCIAL GROUP PLANS

ATTESTATION REGARDING DEPENDENT'S SOCIAL SECURITY NUMBER

Employee Name:_____ Date of Birth: _____
Employer Group: _____

I am the Parent or Legal Guardian (circle one) of _____ (name of dependent child), whose date of birth is _____. I hereby attest as follows:

I am requesting or have applied for enrollment of _____ (name of dependent child) in a health plan or policy offered or underwritten by Memorial Hermann Commercial Health Plan, or Memorial Hermann Health Insurance Company ("Memorial Hermann").

Choose One:

☐ My child does not have a Social Security Number issued by the Social Security Administration, or

☐ My child has a Social Security Number but I am not willing to provide it to Memorial Hermann for the following reasons:

_____

_____

___ (Initials) I understand and agree that if my child is issued a Social Security Number on or after the date of this Attestation, I am responsible for contacting Memorial Hermann at the address/telephone number listed below within ten (10) calendar days to provide Memorial Hermann with the Social Security Number.

___ (Initials) I understand that, as a substitute for the Social Security Number, Memorial Hermann will assign a unique identification code to my child for the purpose of enrolling him or her in the health plan or policy. This unique identification code is for Memorial Hermann's internal purposes only and will not be shared with health care providers or other third parties. Memorial Hermann makes no representations or warranties regarding the policies that other persons, including health care providers in Memorial Hermann's network, may have with respect to the need to furnish a Social Security Number for my child in order to access services.

By my signature below, I represent and warrant that I am the Parent or Legal Guardian of _____ and that all statements contained in this Attestation are true and correct as of the date set forth below. I agree to notify Memorial Hermann if any statement contained in this Attestation becomes false or incorrect following the date of my signature. This Attestation shall be valid and in force until I notify Memorial Hermann in writing that I wish to cancel or nullify this Attestation.

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Name: _____

Signature: _____

Date: _____

Contact Information for Memorial Hermann:
PO BOX 19909
Houston, Texas 77224
Attn: Customer Service Department
855-645-8448
Email: www.healthplan.memorialhermann.org

Memorial Hermann Health Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex.

All Commercial HMO products are underwritten by Memorial Hermann Commercial Health Plan, Inc.
All Commercial PPO products are underwritten by Memorial Hermann Health Insurance Company.

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 855.645.8448 (TTY 711).