

ATTESTATION REGARDING DEPENDENT'S SOCIAL SECURITY NUMBER

Employee Name: _____ Date of Birth: _____

Employer Group: _____

I am the ☐ Parent ☐ Legal Guardian 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
Health Insurance Company, or ("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.

Signature: _____

Print Name: _____

Date: _____

Contact Information for Memorial Hermann:

P.O. Box 19909

Houston, Texas 77224-1909

Attn: Customer Service Department

855-645-8448

<https://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 Hybrid 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).