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

Medical Coverage underwritten by Memorial Hermann Commercial Health Plan, Inc. and Memorial Hermann Health Insurance Company.

EMPLOYEE ENROLLMENT

Memorial Hermann Health Insurance Company ("MHHIC") and Memorial Hermann Commercial Health Plan, Inc. ("MHCHP") GROUP NUMBER

_____
(If existing MHCHP Group)

Consumer Choice Benefit Plans

For HMO products, 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.

1. ENROLLMENT SELECION

☐ New Group Enrollment ☐ Late Enrollment ☐ New Hire ☐ COBRA effective date: |_____|
☐ Family Addition ☐ Re-Enrollment ☐ Change of Coverage ☐ Annual Open Enrollment ☐ State Continuation

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'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 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 Month/Day/Year	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.*

As applicable, enrollee may select an obstetrician or gynecologist as set forth in the Texas Insurance Code Chapter 1451, Subchapter F. 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. MEDICAL COVERAGE

Small Group (group size 2-50):

HMO Plan:_____

PPO Plan: _____

Large Group (group size 51+):

HMO Plan: _____

PPO Plan: _____

With PPO Buy-Up (if applicable): Yes ☐ No ☐

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 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 the qualifying event.

6. OTHER MEDICAL COVERAGE FOR ALL ENROLLING EMPLOYEES AND DEPENDENTS (please answer all questions)

	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. HEALTH QUESTIONNAIRE – THIS SECTION ONLY FOR LARGE 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?	☐	☐

Employee: Height _____ Weight _____ Spouse/Domestic Partner: Height _____ Weight _____

If you answer "YES" to any of the above questions, complete the following: *(Attach additional sheets if necessary).*

Name of patient: _____
Condition/illness: _____
Dates of treatment: From _____ Through _____
Treatment rendered: _____
Still under treatment? ☐ Yes ☐ No
Medication and dosage taken: _____
Date: From _____ Through _____
Treating providers, name/address: _____

Name of patient: _____
Condition/illness: _____
Dates of treatment: From _____ Through _____
Treatment rendered: _____
Still under treatment? ☐ Yes ☐ No
Medication and dosage taken: _____
Date: From _____ Through _____
Treating physicians, name/address: _____

Name of patient: _____
Condition/illness: _____
Dates of treatment: From _____ Through _____
Treatment rendered: _____
Still under treatment? ☐ Yes ☐ No
Medication and dosage taken: _____
Date: From _____ Through _____
Treating providers, name/address: _____

Name of patient: _____
Condition/illness: _____
Dates of treatment: From _____ Through _____
Treatment rendered: _____
Still under treatment? ☐ Yes ☐ No
Medication and dosage taken: _____
Date: From _____ Through _____
Treating physicians, name/address: _____

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 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 Applications have been accepted and approved by MHCHP/MHHIC.

I represent that I have read this and that even if this is approved by MHCHP/MHHIC, any intentional misrepresentation of material fact other than misrepresentation related to health status 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 Group's Plan being rescinded or re-evaluated retroactive to my effective date for eligibility and rating purposes.

Arbitration Agreement: I understand any dispute between MHCHP/MHHIC and me may be subject to binding arbitration. The arbitration will be conducted pursuant to the applicable commercial rules of the Texas Civil Practice and Remedies Code Chapter 171. The arbitration will be binding only if both parties agree and the arbitration will occur in the county where the plan of coverage holder or, if applicable, beneficiary resides. HMO enrollees have a right to pursue legal action and cannot be required to agree to mandatory binding arbitration as arbitration is voluntary. By signing this Application, I am not agreeing to binding arbitration. If I am enrolling in an 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 MHCHP/MHHIC 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 MHCHP/MHHIC I have read all the information provided in response to the questions on this and I represent to MHCHP/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)* **X**	TODAY'S DATE *(Required)*

SIGNATURE OF EMPLOYEE'S SPOUSE'S/ DOMESTIC PARTNER *(If applying for coverage)* **X**	TODAY'S DATE *(Required)*

Incomplete Enrollment Forms will be mailed back to you for completion. This may delay the effective date of your coverage.