

<p><b>GROUP NUMBER</b> (If existing MHHP group)</p> <hr/>
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**EMPLOYEE ENROLLMENT**

Memorial Hermann Health Insurance Company (“MHHC”) / Memorial Hermann Commercial Health Plan (“MHCHP”)  
Medical coverage underwritten by Memorial Hermann Commercial health Plan, Inc. and Memorial Hermann Health Insurance Company.

**[CONSUMER CHOICE BENEFIT PLANS**

For HMO products, you have the option to choose this Consumer Choice Benefits Health Maintenance Organization health care plan that, either in whole or in part, does not provide state-mandated health benefits normally required in evidence 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 SELECTION**

- New Group Enrollment       New Hire       Re-enrollment       Add / Drop Dependent       COBRA
- Annual Open Enrollment       Late Enrollment       Change of Address       Change of Coverage

**2. EMPLOYEE INFORMATION**

LAST NAME	FIRST NAME	MI	FULL TIME DATE OF HIRE	HOME PHONE NO.
STREET ADDRESS		APT. NO.	PRIMARY LANGUAGE	MOBILE PHONE NO
MAILING ADDRESS (if different)			ARE YOU MARRIED? <input type="checkbox"/> YES <input type="checkbox"/> NO	BUSINESS PHONE NO.
CITY	STATE	ZIP CODE	EMPLOYEE/SPOUSE MAIDEN NAME	
EMPLOYER NAME	OCCUPATION / JOB TITLE		<input type="checkbox"/> Check if you would like to receive Your Plan materials electronically.**	EMAIL ADDRESS

\*\* You have the right to withdraw your consent for electronic communications and request paper copies at any time. To withdraw consent, please call Customer Service at (855) 645-8448.

### 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; children with a medical support order; adopted children under age 26, including a child for whom the Eligible Employee is a party in a suit to adopt or placed for adoption; unmarried grandchildren who are under age 26 and are Dependents for federal income tax purposes at the time of this enrollment form; or disabled Dependents over 26 who are medically disabled and Dependent on parent.

◆ Section 4302 of the Affordable Care Act (Understanding Health Disparities: Data Collection and Analysis) requires the Department of Health and Humana Services (DHHS) to establish data collection standards for race, ethnicity, sex, primary language, and disability status, for the purpose of identifying racial and ethnic health disparities, understanding the causes and correlations, and monitoring progress in reducing them.

◆ Race / Ethnicity:															
01 – White		02 – Black / African American		03 – American Indian / Alaska Native		04 – Asian		05 - Native Hawaiian / Pacific Islander		06 – Other Race 07 – Two or More Ethnicity		08 - Declined		09 - Unknown Ethnicity	
Relationship	Sex	Last Name	First Name	MI	Date of Birth	Tobacco User*?	Disabled?	Disability affecting ability to communicate or read?	Race / Ethnicity	Social Security # **	PCP Name & ID Number (For HMO coverage only)				
Employee	<input type="checkbox"/> M <input type="checkbox"/> F					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No							
Spouse/ Domestic Partner	<input type="checkbox"/> M <input type="checkbox"/> F					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No							
Address (if Different from Employee):									Mobile Phone No:		<input type="checkbox"/> Text <input type="checkbox"/> Opt-In	Email:			
Dependent 1	<input type="checkbox"/> M <input type="checkbox"/> F					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No							
Address (if Different from Employee):									Mobile Phone No (18 yrs. and older):		<input type="checkbox"/> Text <input type="checkbox"/> Opt-In	Email (18 and older):			
Dependent 2	<input type="checkbox"/> M <input type="checkbox"/> F					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No							
Address (if Different from Employee):									Mobile Phone No (18 yrs. and older):		<input type="checkbox"/> Text <input type="checkbox"/> Opt-In	Email (18 and older):			
Dependent 3	<input type="checkbox"/> M <input type="checkbox"/> F					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No							
Address (if Different from Employee):									Mobile Phone No (18 yrs. and older):		<input type="checkbox"/> Text <input type="checkbox"/> Opt-In	Email (18 and older):			

\*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), the Social Security Attestation Form will need to be completed.

As applicable, enrollee may select an in-network obstetrician or gynecologist, in addition to a PCP, as set forth in the Texas Insurance Code Chapter 1451, Subchapter F. Enrollee may designate the selection here:

Enrollee Name:	Provider Name & Address:

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**

HMO Plan Name:	PPO Plan Name:
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**5. COVERAGE DECLINATION**

*To be completed if any coverage is declined or refused by an Eligible Employee and/or their Eligible Family members.*

Declining Group Medical Coverage (Please Check all applicable Boxes for each person.)	Covered by Spouse / Domestic Partner's Group Coverage	Covered by Individual Insurance Policy	Covered by Medicare	Covered by TRICARE	Covered by Medicaid / CHIP	No current Health coverage
<b>Employee (Name)</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Name of Insurance Company</b>			<b>Member ID</b>			
<b>Spouse/Domestic Partner (Name)</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Name of Insurance Company</b>			<b>Member ID</b>			
<b>Dependent (Name)</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Name of Insurance Company</b>			<b>Member ID</b>			
<b>Dependent (Name)</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Name of Insurance Company</b>			<b>Member ID</b>			
<b>Dependent (Name)</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Name of Insurance Company</b>			<b>Member ID</b>			
<b>Other Reason for Declining (Please Explain)</b>						

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 party in suit to adopt, or receive a medical support order for a child (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.)**

Do any persons on this enrollment form intend to continue other coverage if this enrollment is accepted? If, so, please complete below.  Yes  No

Name	Insurance Company	Policy No.	Member ID	Effective Date	Termination Date

**7. HEALTH QUESTIONNAIRE– (Please answer all questions.)**

- |   | Yes                      | No                       |
|---|--------------------------|--------------------------|
| A. 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:<br>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; cancer? ..... | <input type="checkbox"/> | <input type="checkbox"/> |
| B. 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? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| C. 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 of more than \$5,000? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| D. Is any person listed on this Enrollment form:  |                          |                          |
| 1) Currently under treatment, receiving counseling, or taking medication for any condition or disease? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 2) Currently pregnant, or is any male expecting a child with anyone, whether listed on this Enrollment form or not? If yes, what is the expected due date (MM/DD/YY)? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 3) A user of tobacco products within the last 2 years? .....  | <input type="checkbox"/> | <input type="checkbox"/> |

Employee: Height \_\_\_\_\_ Weight \_\_\_\_\_

Spouse/Domestic Partner: Height \_\_\_\_\_ Weight \_\_\_\_\_

**If you answer “YES” to any of the above medical 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: \_\_\_\_\_  
 Dates Taken: From \_\_\_\_\_ Through \_\_\_\_\_  
 Provider’s Name: \_\_\_\_\_  
 Address: \_\_\_\_\_

Name of Patient: \_\_\_\_\_  
 Condition / Illness: \_\_\_\_\_  
 Dates of Treatment: From \_\_\_\_\_ Through \_\_\_\_\_  
 Treatment Rendered: \_\_\_\_\_  
 Still Under Treatment?     Yes     No  
 Medication and Dosage: \_\_\_\_\_  
 Dates Taken: From \_\_\_\_\_ Through \_\_\_\_\_  
 Provider’s Name: \_\_\_\_\_  
 Address: \_\_\_\_\_

Name of Patient: \_\_\_\_\_  
Condition / Illness: \_\_\_\_\_  
Dates of Treatment: From \_\_\_\_\_ Through \_\_\_\_\_  
Treatment Rendered: \_\_\_\_\_  
Still Under Treatment?     Yes     No  
Medication and Dosage: \_\_\_\_\_  
Dates Taken: From \_\_\_\_\_ Through \_\_\_\_\_  
Provider's Name: \_\_\_\_\_  
Address: \_\_\_\_\_

Name of Patient: \_\_\_\_\_  
Condition / Illness: \_\_\_\_\_  
Dates of Treatment: From \_\_\_\_\_ Through \_\_\_\_\_  
Treatment Rendered: \_\_\_\_\_  
Still Under Treatment?     Yes     No  
Medication and Dosage: \_\_\_\_\_  
Dates Taken: From \_\_\_\_\_ Through \_\_\_\_\_  
Provider's Name: \_\_\_\_\_  
Address: \_\_\_\_\_

Name of Patient: \_\_\_\_\_  
Condition / Illness: \_\_\_\_\_  
Dates of Treatment: From \_\_\_\_\_ Through \_\_\_\_\_  
Treatment Rendered: \_\_\_\_\_  
Still Under Treatment?     Yes     No  
Medication and Dosage: \_\_\_\_\_  
Dates Taken: From \_\_\_\_\_ Through \_\_\_\_\_  
Provider's Name: \_\_\_\_\_  
Address: \_\_\_\_\_

Name of Patient: \_\_\_\_\_  
Condition / Illness: \_\_\_\_\_  
Dates of Treatment: From \_\_\_\_\_ Through \_\_\_\_\_  
Treatment Rendered: \_\_\_\_\_  
Still Under Treatment?     Yes     No  
Medication and Dosage: \_\_\_\_\_  
Dates Taken: From \_\_\_\_\_ Through \_\_\_\_\_  
Provider's Name: \_\_\_\_\_  
Address: \_\_\_\_\_

Name of Patient: \_\_\_\_\_  
Condition / Illness: \_\_\_\_\_  
Dates of Treatment: From \_\_\_\_\_ Through \_\_\_\_\_  
Treatment Rendered: \_\_\_\_\_  
Still Under Treatment?     Yes     No  
Medication and Dosage: \_\_\_\_\_  
Dates Taken: From \_\_\_\_\_ Through \_\_\_\_\_  
Provider's Name: \_\_\_\_\_  
Address: \_\_\_\_\_

Name of Patient: \_\_\_\_\_  
Condition / Illness: \_\_\_\_\_  
Dates of Treatment: From \_\_\_\_\_ Through \_\_\_\_\_  
Treatment Rendered: \_\_\_\_\_  
Still Under Treatment?     Yes     No  
Medication and Dosage: \_\_\_\_\_  
Dates Taken: From \_\_\_\_\_ Through \_\_\_\_\_  
Provider's 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 myself 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. 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 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 that 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 form. I represent to MHCHP/MHHIC that I have read all the information provided in response to the questions on this and I represent to MHCHP/MHHIC that such information is true, complete and accurate as of the current date.

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

<b>SIGNATURE OF EMPLOYEE</b> <i>(Required)</i>	<b>TODAY'S DATE</b> <i>(Required)</i>
X	

<b>SIGNATURE OF SPOUSE / DOMESTIC PARTNER</b> <i>(If Applying for Coverage)</i>	<b>TODAY'S DATE</b> <i>(Required)</i>
X	

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

Health plan coverage is underwritten by Memorial Hermann Commercial Health Plan, Inc. and Memorial Hermann Health Insurance Company. The Memorial Hermann Commercial Health Plan, Inc. and Memorial Hermann Health Insurance Company logos are a registered trademark of Memorial Hermann Health System.