Employer Name	
Group/Division #	
Dental/Division #	
Life/Division #	

(Mandatory)

Group HMO Enrollment Application & Change Form

SECTION 1: REQUESTED ACTION		Please check all that apply – Complete section 5 if declining coverage			
√	**New Enrollee**	√	**Termination**	√	**Change**
☐	Open Enrollment	☐	Terminate **Medical** Coverage (All Members)	☐	Add Dependent(s)
☐	**New Hire/Rehire**	☐	Terminate **Medical** Dependent(s) Coverage	☐	Change Plan Option
☐	Birth/Adoption	☐	Terminate **Dental** Coverage (All Members)	☐	Demographic Change(s)
☐	Late Enrollee	☐	Terminate **Dental** Dependent(s) Coverage		**HIRE DATE:**_______________ **(Mandatory)**
☐	Marriage Date(Proof of Marriage Required)	☐	Terminate **Life** Coverage (Employee Only)		
☐	Loss of Coverage (Proof of Loss Required)		Reason:_________________________________		
☐	Court Order (Court Order or Decree Required)		____		**TERM DATE:**_______________

SECTION 2: EMPLOYEE INFORMATION

First Name | MI | Last Name | Suffix

* Social Security Number | Date of Birth (MM/DD/YYYY) | ☐ Male ☐ Female | Employment Status: ☐ Exempt ☐ Non Exempt ☐ Retired

Marital Status ☐ Single/Divorced/Widow ☐ Married ☐ Other__________________ | Primary Language: ☐ English ☐ Spanish ☐ Other (Please Specify):_______________________

Residential Address | Apt | City | State | Zip | County

Mailing Address (If different than above) | Apt | City | State | Zip | County

Primary Phone Cell ☐ Landline ☐ | Secondary Phone Cell ☐ Landline ☐

Email Address | Preferred Contact Method ☐ Email ☐ Mail

Do you have a disability affecting your ability to communicate or read? ☐ Yes ☐ No

Will you enroll in Dental Coverage? ☐ Yes ☐ No | Will you enroll in Life Insurance Coverage? ☐ Yes ☐ No

SECTION 3: DEPENDENT INFORMATION

DEPENDENT

First Name | MI | Last Name | Suffix

* Social Security Number | Date of Birth (MM/DD/YYYY) | ☐ Spouse ☐ Child ☐ Grand Child | ☐ Male ☐ Female

Disability affecting your ability to communicate or read? ☐ Yes ☐ No | Primary Language: ☐ English ☐ Spanish ☐ Other

Will you enroll in Dental Coverage? ☐ Yes ☐ No | Will you enroll in Life Insurance Coverage? ☐ Yes ☐ No

DEPENDENT

First Name | MI | Last Name | Suffix

* Social Security Number | Date of Birth (MM/DD/YYYY) | Relationship ☐ Child ☐ Grand Child | ☐ Male ☐ Female

Disability affecting your ability to communicate or read? ☐ Yes ☐ No | Primary Language: ☐ English ☐ Spanish ☐ Other

Will you enroll in Dental Coverage? ☐ Yes ☐ No | Will you enroll in Life Insurance Coverage? ☐ Yes ☐ No

DEPENDENT

First Name | MI | Last Name | Suffix

* Social Security Number | Date of Birth (MM/DD/YYYY) | Relationship ☐ Child ☐ Grand Child | ☐ Male ☐ Female

Disability affecting your ability to communicate or read? ☐ Yes ☐ No | Primary Language: ☐ English ☐ Spanish ☐ Other

Will you enroll in Dental Coverage? ☐ Yes ☐ No | Will you enroll in Life Insurance Coverage? ☐ Yes ☐ No

DEPENDENT

First Name | MI | Last Name | Suffix

* Social Security Number | Date of Birth (MM/DD/YYYY) | Relationship ☐ Child ☐ Grand Child | ☐ Male ☐ Female

Disability affecting your ability to communicate or read? ☐ Yes ☐ No | Primary Language: ☐ English ☐ Spanish ☐ Other

Will you enroll in Dental Coverage? ☐ Yes ☐ No | Will you enroll in Life Insurance Coverage? ☐ Yes ☐ No

Employer Name	
Group/Division #	
Dental/Division #	
Life/Division #	

(Mandatory)

SECTION 4: OTHER COVERAGE	
Will you or your dependents, applying for coverage, be covered under another group health plan? ☐ Yes ☐ No (If yes, complete below)	
Insurance Company Name	Name of Policyholder

SECTION 5: DECLINATION OF COVERAGE

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself of your dependents in this plan, provided that you request enrollment within 31 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

☐ I decline enrollment in Scott and White Health Plan during my initial eligibility period due to the reason listed below. (**employee)**

☐ I decline enrollment in Scott and White Health Plan for my **dependents** during my initial eligibility period due to the reason listed below.

Reason for Declining Coverage:

☐ I and/or my dependents are covered under another health plan benefits plan. Other:

I have not been discouraged by Group or Health Plan from enrolling for coverage.

SECTION 6: DISCLOSURES

[**Consumer Choice Benefit Plans**: 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 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.]

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.

SECTION 7: ACKNOWLEDGMENT SIGNATURE

I hereby certify to the best of my knowledge the answers given are correct, truthful, and complete. Further, I hereby authorize my licensed physician, medical practitioner, hospital, clinic or other medically related facility, organization, institution, or person, that has any records or knowledge of me, my family or our health, to give Scott and White Health Plan any such information requested. A photographic copy of this authorization shall be valid. I understand that I or my dependents may be covered by another group insurance and I will cooperate fully with the health Plan in providing information necessary to coordinate benefits.

Signature:	Print Name:	Date (MM/DD/YYYY)

Send completed application by one of the following methods:	**Email:**	Email: swhpgroupenrollment@sw.org ***Subject line: Group Name/Group Number/Division***
	Fax:	Fax 254-298-3199
	Mail:	Scott and White Health Plan MS-A4-126 1206 West Campus Drive Temple, TX 76502
	Portal:	If applicable If experiencing issues with application on portal, please email swhpgroupenrollment@sw.org with Request ID#.

English:
ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-321-7947 (TTY: 1-800-735-2989). Scott & White 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.

Spanish:
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-321-7947 (TTY: 1-800-735-2989). Scott & White Health Plan cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo.

Vietnamese:
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800 321-7947 (TTY: 1-800-735-2989). Scott & White Health Plan tuân thủ luật dân quyền hiện hành của Liên bang và không phân biệt đối xử dựa trên chủng tộc, màu da, nguồn gốc quốc gia, độ tuổi, khuyết tật, hoặc giới tính.

Chinese:
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-321-7947（TTY：1-800-735-2989）。Scott & White Health Plan 遵守適用的聯邦民權法律規定，不因種族、膚色、民族血統、年齡、殘障或性別而歧視任何人。

Korean:
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-321-7947 (TTY: 1-800-735-2989) 번으로 전화해 주십시오. Scott & White Health Plan 은(는) 관련 연방 공민권법을 준수하며 인종, 피부색, 출신 국가, 연령, 장애 또는 성별을 이유로 차별하지 않습니다.

Arabic:
ملحوظة: إذا كنت تتحدث انكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-321-7947 (رقم هاتف الصم والبكم: 1-800-735-2989).
يلتزم Scott & White Health Plan بقوانين الحقوق المدنية الفدرالية المعمول بها ولا يميز على أساس العرق أو اللون أو الأصل الوطني أو السن أو الإعاقة أو الجنس.

Urdu:
خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کریں 1-800-321-7947 (TTY: 1-800-735-2989).
Scott & White Health Plan قابل اطلاق وفاقی شہری حقوق کے قوانین کی تعمیل کرتا ہے
اور یہ کہ نسل، رنگ ، قومیت، عمر، معذوری یا جنس کی بنیاد پر امتیاز نہیں کرتا۔

Tagalog:
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-321-7947 (TTY: 1-800-735-2989). Sumusunod ang Scott & White Health Plan sa mga naaangkop na Pederal na batas sa karapatang sibil at hindi nandidiskrimina batay sa lahi, kulay, bansang pinagmulan, edad, kapansanan o kasarian.

French:
ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-321-7947 (ATS : 1-800-735-2989). Scott & White Health Plan respecte les lois fédérales en vigueur relatives aux droits civiques et ne pratique aucune discrimination basée sur la race, la couleur de peau, l'origine nationale, l'âge, le sexe ou un handicap.

Hindi:
ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-800-321-7947 (TTY: 1-800-735-2989) पर कॉल करें। Scott & White Health Plan लागू होने योग्य संघीय नागरिक अधिकार क़ानून का पालन करता है और जाति, रंग, राष्ट्रीय मूल, आयु, विकलांगता, या लिंग के आधार पर भेदभाव नहीं करता है।

Persian:
توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با(1-800-321-7947 (TTY: 1-800-735-2989 تماس بگیرید.
Scott & White Health Plan از قوانین حقوق مدنی فدرال مربوطه تبعیت می کند و هیچگونه تبعیضی بر اساس نژاد، رنگ پوست، اصلیت ملیتی، سن، ناتوانی یا جنسیت افراد قایل نمی شود.

German:
ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-321-7947 (TTY: 1-800-735-2989). Scott & White Health Plan erfüllt geltenden bundesstaatliche Menschenrechtsgesetze und lehnt jegliche Diskriminierung aufgrund von Rasse, Hautfarbe, Herkunft, Alter, Behinderung oder Geschlecht ab.

Gujarati:
સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-800-321-7947 (TTY: 1-800-735-2989). Scott & White Health Plan લાગુ પડતા સમવાયી નાગરિક અધિકાર કાયદા સાથે સુસંગત છે અને જાતિ, રંગ, રાષ્ટ્રીય મૂળ, ઉંમર, અશક્તતા અથવા લિંગના આધારે ભેદભાવ રાખવામાં આવતો નથી.

Russian:
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-321-7947 (телетайп: 1-800-735-2989). Scott & White Health Plan соблюдает применимое федеральное законодательство в области гражданских прав и не допускает дискриминации по признакам расы, цвета кожи, национальной принадлежности, возраста, инвалидности или пола.

Japanese:
注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-321-7947 (TTY:1-800-735-2989）まで、お電話にてご連絡ください。Scott & White Health Plan は適用される連邦公民権法を遵守し、人種、肌の色、出身国、年齢、障害または性別に基づく差別をいたしません。

Laotian:
ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-800-321-7947 (TTY: 1-800-735-2989). Scott & White Health Plan ປະຕິບັດຕາມກົດໝາຍວ່າດ້ວຍສິດທິພົນລະເມືອງຂອງລັດຖະບານກາງທີ່ບັງຄັບໃຊ້ ແລະບໍ່ຈຳແນກໂດຍອີງໃສ່ພື້ນຖານຕົ້ນເຊື້ອຊາດ, ສີຜິວ, ຊາດກຳເນີດ, ອາຍຸ, ຄວາມພິການ, ຫຼື ເພດ.