GROUP NUMBER
(If existing MHHP group)

_____

MEMORIAL HERMANN Health Plan
COMMERCIAL GROUP PLANS

EMPLOYEE ENROLLMENT

Memorial Hermann Health Solutions, Inc. ("MHHSI")
Medical Coverage administered by Memorial Hermann Health Solutions, Inc.

1. ENROLLMENT SELECTION

☐ New Group Enrollment	☐ New Hire	☐ Change of Address	☐ Add / Drop Dependent	If adding Spouse, list Date of Marriage:
☐ Annual Open Enrollment	☐ Late Enrollment	☐ Change of Coverage	☐ Re-enrollment	_____
☐ COBRA	COBRA Effective Date:	Original Effective Date:	Reason for COBRA:	
	_____	_____	_____	

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?** ☐ **YES** ☐ **NO**	**BUSINESS PHONE NO.**
CITY	**STATE**	**ZIP CODE**	**EMPLOYEE/SPOUSE MAIDEN NAME**	
EMPLOYER NAME	**OCCUPATION / JOB TITLE**		☐ **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.

♦ *The collection of data regarding race, ethnicity, sex, primary language, and disability status is for the purpose of identifying racial and ethnic health disparities, understanding the causes and correlations, and monitoring progress in reducing them.*

♦ **Race / Ethnicity: (Optional)** 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 Ethnicities; 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	☐ M ☐ F					☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No			
Spouse / Domestic Partner	☐ M ☐ F					☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No			
Address (if Different from Employee):							**Mobile Phone No:**		☐ Text Opt-In	**Email:**	
Dependent 1	☐ M ☐ F					☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No			
Address (if Different from Employee):							**Mobile Phone No** (18 yrs. and older):		☐ Text Opt-In	**Email (18 and older):**	
Dependent 2	☐ M ☐ F					☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No			
Address (if Different from Employee):							**Mobile Phone No** (18 yrs. and older):		☐ Text Opt-In	**Email (18 and older):**	
Dependent 3	☐ M ☐ F					☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No			
Address (if Different from Employee):							**Mobile Phone No** (18 yrs. and older):		☐ Text 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:

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
Employee (Name)	☐	☐	☐	☐	☐	☐
Name of Insurance Company			**Member ID**			
Spouse/Domestic Partner (Name)	☐	☐	☐	☐	☐	☐
Name of Insurance Company			**Member ID**			
Dependent (Name)	☐	☐	☐	☐	☐	☐
Name of Insurance Company			**Member ID**			
Dependent (Name)	☐	☐	☐	☐	☐	☐
Name of Insurance Company			**Member ID**			
Dependent (Name)	☐	☐	☐	☐	☐	☐
Name of Insurance Company			**Member ID**			
Other Reason for Declining (Please 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 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

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 MHHSI.

I represent that I have read this and that even if this is approved by MHHSI, 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 MHHSI 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 MHHSI 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 MHHSI that I have read all the information provided in response to the questions on this and I represent to MHHSI that 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 SPOUSE / 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.