Individual and Family Plans
Insurance Company of SCOTT&WHITE
The one Texans trust.

Short-Term Enrollment Application
Individual & Family Plans (IFP)
Preferred Provider Organization (PPO)

If you have questions, please contact a sales representative at 1-866-522-2515,
Monday – Friday, 8:00 AM – 5:00 PM.

Submit by Fax:	**Submit by mail:**
Attention Individual & Family Plans	**Insurance Company of Scott & White** **Attention Individual & Family Plans**
[979-846-6962] **[512-930-6055]** **[325-659-1549]** **[254-298-3567]** **[254-756-8080]**	**[3000 Briarcrest, Suite 422, Bryan, TX 77802]** **[204 S. IH-35, Suite 100, Georgetown, TX 78628]** **[1131 Knickerbocker, Suite B, San Angelo, TX 76903]** **[1206 West Campus Drive, Temple, TX 76502]** **[200 W. State Highway 6, Suite 300, Waco, TX 76712]**

APPLICATION INSTRUCTIONS

1. This application must be completed with black or blue ink only. Illegible applications or applications completed in pencil or erasable ink will be returned. No changes or corrections to this application, if a change needs to be made you must complete a new application. DO NOT use correction tape or fluid.

2. All questions must be answered. You are responsible for the accuracy and completeness of all information entered on this form. Full disclosure is essential in processing your application. Any misrepresentation or omission of the presence of an existing condition, impairment or disease will be subject to medical review, upon discovery, and if determined to be fraud or intentional misrepresentation, rescission of the policy. Incomplete applications may result in delays and/or declination.

3. The Insurance Company of Scott & White (ICSW) Plans for Individuals and Families are not guaranteed issue plans. All applicants enrolling including spouse and dependents are subject to medical underwriting to determine eligibility.

4. All legal-age applicants or the parent/legal guardian of a minor child applicant must personally sign and date this application. All applicants age 18 or over must personally sign and date this application on the appropriate signature line.

5. Applicants must be under the age of 65 and Dependent children must be under the age of 26.

6. If you applied for a Short Term policy with ICSW in the last 3 months and been declined, you are not eligible to re-apply and your application will be disregarded.

Individual and Family Plans
Insurance Company of SCOTT&WHITE
The one Texans trust.

Insurance Company of Scott & White (ICSW) Application for Short-Term Health Insurance

Office Use Only:
Agent:_____
Premium: _____

SECTION 1: APPLICATION INFORMATION

☐ New Application ☐ Reapplication ☐ Add Member

How did you hear about our plans? ☐Broker ☐Newspaper ☐TV ☐Radio ☐Door Hanger ☐Other

SECTION 2: PRIMARY APPLICANT(s) OR PURCHASER FOR CHILD ONLY POLICY INFORMATION

Last Name:	First Name:	MI:	Home phone: ( )
Email:	Do you have a disability or language barrier which affects your ability to communicate or read? ☐ YES ☐ NO If "Yes", please describe.		Alternate Phone: ( ) Work/Cell

Billing Address :	City:	State:	Zip:
Residential Address:	City:	State:	Zip:

☐ I am applying for coverage for myself or myself and dependents (skip to Section 3)
☐ I am not applying for coverage; I am the purchaser for a child only policy (this information must be provided for a child or children under age 18. (Skip to Section 4)

SECTION 3: PRIMARY APPLICANT'S INFORMATION

Gender ☐M ☐F	Birth date: ___/___/___	Age:	Maiden/Other Name:	SS#:

SECTION 4: Other Applicants: Legal spouse / dependent children or applicant(s) for Child only Policy

(Dependent children must be 90 days of age and under age 26; Child Only applicants must be 90 days of age and under age 18).

Type Applicant	Last Name:	First Name :	MI	Spouse's Maiden/ Child's Relationship	Gender	DOB	Age	SS#
Spouse					M ☐ F ☐	/ /		
Child01					M ☐ F ☐	/ /		
Child02					M ☐ F ☐	/ /		
Child03					M ☐ F ☐	/ /		
Child04					M ☐ F ☐	/ /		
Child05					M ☐ F ☐	/ /		
Child06					M ☐ F ☐	/ /		

If adoptee, give the date the adopted child was placed with you: _____

If any one applicant is denied coverage, do you wish to cover the remaining applicants? ☐ Yes ☐ No

SECTION 5: RESIDENTIAL ADDRESS INFORMATION

Does any one listed in Section 4 have a different residential address than what was given in Section 2? ☐ Yes ☐ No
If "Yes" please give applicants names and residential address below

First Name:	Address:	City/ State/ Zip Code:	First Name:	Address:	City/ State/ Zip Code:

SECTION 6: COVERAGE OPTIONS

☐ **Plan ST 80 includes RX**	Deductibles:	☐ $500	☐ $1000	☐ $1500
☐ **Plan ST 80 no RX**	Deductibles:	☐ $2500	☐ $5000	☐ $10,000

☐ *Make my Effective date the 1st available date*
☐ *I want ___/___/____ to be the Effective date (must be within 15 days of this application signature date)*
Important: Do not cancel any coverage you may have until you have received confirmation of acceptance from the ICSW.

SECTION 7: PREVIOUS ICSW MEDICAL COVERAGE

Has any applicant ever applied for Individual coverage with the Scott & White Health Plan (SWHP) or ICSW? ☐ Yes ☐ No
If "Yes", list individual(s) and year(s) applied:

Is any applicant applying for coverage a current or former member of SWHP or ICSW? ☐ Yes ☐ No
If "Yes", list individual(s) and year(s) of coverage:

SECTION 8: MEDICAL QUESTIONNAIRE

- **<u>If you answer "Yes" to any question in Section 8, PLEASE list all applicants that it applies to in Section 9.</u>**
- **All applicants that answer "Yes" to questions 1-7 will not be issued coverage.**

By completing and signing this application you are stating that "you have answered <u>all</u> questions truthfully and to the best of your knowledge or belief for all applicants applying".

1. **Are you or any person applying or <u>member of your household</u> (whether or not named in this application): now pregnant, an expectant parent, in the process of adopting a child or undergoing infertility testing or treatment?**	☐ Yes ☐ No
2. **Have you or any person applying been diagnosed with or treated for any immune system disorders, including but not limited to, Acquired Immune Deficiency Syndrome (AIDS), AIDS-related complex including HIV infection, or tested positive for HIV infection?**	☐ Yes ☐ No
3. **Have you or any person applying for coverage in the past five years, been aware of, advised on, consulted a member of the medical profession, tested, diagnosed, treated, hospitalized, taken medication for, had symptoms of or been recommended for treatment for any of the following:** a. Heart disorder, heart attack, coronary artery disease, coronary bypass or stent; peripheral vascular disease or carotid artery disease; TIA, and /or stroke? b. Diabetes? c. Cancer (Other than Basal or Squamous Cell)? d. Disorder of the blood? e. Kidney disorder, (Other than Kidney Stones)? f. Alcoholism or alcohol abuse; drug abuse, addiction or dependency? g. Emphysema, chronic obstructive pulmonary disease (COPD)? h. Liver disorders, including cirrhosis or hepatitis B or C? i. Crohn's disease, ulcerative colitis? j. Paraplegia, quadriplegia or multiple sclerosis; rheumatoid or psoriatic arthritis; degenerative disc disease; degenerative joint disease of the knees or hips?	☐ Yes ☐ No
4. **Are you or any person applying planning on participating in motor vehicle or boat racing; mountain climbing; bungee jumping; steer wrestling, bull or bronco riding; hang gliding, sky diving or other extreme sports during this coverage?**	☐ Yes ☐ No
5. **Will you or any person applying on this contract be residing outside the ICSW service area during this coverage?**	☐ Yes ☐ No
6. **Are you or any person applying, to be insured NOT a U.S. citizen or a permanent resident living in the United States for at least 1 year?**	☐ Yes ☐ No
7. **Will you or any person applying have other group or individual major medical health insurance or Medicaid policy in force on the effective date?**	☐ Yes ☐ No
8. **Have you or any person applying, been hospitalized in the last 60 days?**	☐ Yes ☐ No
If applying for the Prescription benefit please answer question 9. If you answer "Yes" to question 9, please provide the names of the applicants and details to which the "Yes" answer(s) apply, below in section 9. *(If you answer yes to question 9 below, you do not qualify for the prescription benefit)*	
9. **Have you or any person applying been diagnosed with or treated for Attention Deficient Disorder (ADD), Attention Deficient Hyperactive Disorder (ADHD), Bi-polar Disorder, Schizophrenia, Psychotic Disorder or Neurosis?**	☐ Yes ☐ No

If you answered "Yes" to any question in Section 8, please provide the names of the applicants to which the "Yes" answers apply, below in section 9.

SECTION 9: DETAILS OF HEALTH HISTORY For "Yes" Answers

Question #, Applicant, Provide Specific condition and details

SECTION 10: CERTIFICATION AND AUTHORIZATION FOR RECORDS RELEASE

This enrollment application must be updated to include any change in health status or medical impairment, including pregnancy, which occurs between the signature date of this application and the date of becoming an insured member. Failure to provide this information to the ICSW will constitute a misrepresentation of the presence of an existing condition, impairment or disease that will be subject to medical review, upon discovery, and, if determined to be fraud or intentional misrepresentation, rescission of the policy.

I understand that coverage with the ICSW is not automatic. The information provided by me on this application is used by the ICSW and is material to its decision to either, accept or decline my coverage. I therefore certify that the information that I have provided is truthful, complete, and made to the best of my knowledge and belief. I acknowledge that any incorrect or incomplete information contained in this application that is determined to be fraud or intentional misrepresentation may cause the ICSW to void my coverage, if it is determined, that had this information been disclosed on the application, that the ICSW would have declined my coverage.

Further, I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, the Medical Information Bureau, Pharmacy Benefit Manager or other organization, institution, or person, that has any records or knowledge of me or my family's health, to give to the ICSW, or its reinsurers or business associates, any such medical or treatment information that it may request, if permitted by law, including but not limited to any information pertaining to psychiatry/psychology, drug/alcohol usage, and HIV/AIDS. I also grant the ICSW to disclose the reason(s) and source for any denial of coverage to my designated broker (if applicable) and to myself and to my physician, if requested. This includes release of information obtained through claims, telephone interview, medical records, or third-party databases. I understand that my authorized disclosure of protected health information carries with it the potential for re-disclosure and may no longer be protected by the Federal privacy laws. I understand that I may revoke this authorization in writing at any time, except to the extent that the ICSW or any health care provider has already relied on this authorization. I understand that I may revoke this authorization by providing the ICSW with a written request for revocation stating my intent to revoke this authorization. This authorization expires 24 months from the date the authorization is signed. The ICSW may deny my enrollment or eligibility for benefits if I fail to complete this authorization form.

I understand that the ICSW may not have conducted a review of my medical records or obtained copies of my records from all of my doctors, clinics, and other health facilities. To the extent allowed by law, if the ICSW later finds evidence of a medical condition which I did not list on this form and which could legally be used to deny coverage, the ICSW will terminate my coverage. I understand that in the absence of complete medical records, a general physical may be required and will be at my own expense.

Upon review of my application, I will receive notification by mail of my insurability. If the application has been approved, the initial monthly premium payment must be paid in advance prior to the issuance of a policy and a notification will be sent which includes the premium amount and the deadline for remittance prior to the effective date of coverage. I understand that medical information acquired by the ICSW is confidential and protected by law. In this regard, I understand that the ICSW employees are not allowed to reveal the ICSW's basis for approval or denial of my application unless the ICSW is required to reveal that basis through a legal process and as I grant the authorization to reveal the details to my broker or to myself. The ICSW will not approve or deny my application on any basis which is prohibited by law. I hereby certify that to the best of my knowledge the answers given here are current, truthful, and complete. A photographic copy of this authorization shall be as valid as the original.

Print Name of Primary Applicant or If Child Only Policy	Signature of Primary Applicant /Parent/Guardian or If Child Only Policy	Date
Print Name of Parent/Guardian (sign for dependent(s) below	Signature of Parent/Guardian sign for dependent(s) below	Date

If applying (dependents 18 years of age and older must sign for themselves unless parent/guardian has Power of Attorney:

Print Name of Spouse	Signature of Spouse	Date
Print Name of Dependent	Signature of Parent /Guardian of Dependent	Date
Print Name of Dependent	Signature of Parent/Guardian of Dependent	Date
Print Name of Dependent	Signature of Parent/Guardian of Dependent	Date
Print Name of Dependent	Signature of Parent/Guardian of Dependent	Date
Print Name of Dependent	Signature of Parent/Guardian of Dependent	Date
Print Name of Dependent	Signature of Parent/Guardian of Dependent	Date

THIS APPLICATION WILL EXPIRE Thirty (30) DAYS FROM THE ABOVE SIGNATURE DATE

Authorization for Prepayments to the Insurance Company of Scott & White (ICSW)

If approved, your coverage will become effective on the later of your requested effective date or the day after application and payment are received by the ICSW, the last 3 calendar days of the month are not available effective dates.

The ICSW Individual & Family Plans are pre-paid health insurance coverage, which means you pay your initial premium payment and subsequent payments for coverage prior to the month of coverage. If you are approved for coverage, you will receive an acceptance letter with notification of the effective date of coverage with the names of each individual applicant who has been approved for coverage, plus the premium amount that will be charged to your account. You may change your banking information by contacting the ICSW Customer Service via email at "SWHP.org" or by calling 800-321-7947, Monday – Friday, 8:00 AM – 5:00 PM. (Any changes will be dependent on the time of month the request is received by ICSW.)

Any initial premium payments sent before acceptance by the ICSW will not constitute approval or acceptance of health insurance coverage or bind coverage by the ICSW, including but not limited to any deposit, negotiation, or holding of such premiums or payments by the ICSW. I understand and agree that notwithstanding anything in the application to the contrary; no coverage shall be considered accepted until approved by the ICSW.

Select Effective Dates (the last 3 calendar days of the month are not available)

☐ Next Available (*Coverage begins the day after application & payment are received by ICSW*)
☐ Select Effective date (*Must be a future date & less than 15 days from date application signed)* ____/_____/20_____

Select your Duration of Coverage

☐ 1 Month ☐ 2 Months ☐ 3 Months ☐ 4 Months ☐ 5 Months ☐ 6 Months
☐ 7 Month ☐ 8 Months ☐ 9 Months ☐ 10 Months ☐ 11 Months

Select Term Date

☐ No specific date needed (*e.g. If effective on the 12th of 1st month, policy will term on the 11th of the last month.*)
☐ Select Specific Term Date (*Must be greater than 1 calendar month from effective date)* _____/_____/20_____

I want to pay my premiums : ☐ Monthly ☐ Pay the full amount of the premiums for the life of the contract

Premium Payment Bank Draft Information:

Draft*: Occurs the 1st business day of the month* ***Note: If you have 2 or more types of policies, each will draft separately***

☐ Checking Account ☐ Savings Account Name of Financial Institution:_____
Account Number: _____ Routing Number: _____
Name on Account: _____
Authorized Signature for Account: _____ Date:_____
Primary Contract Holder(s) Print Name(s): _____, _____,
_____, _____, _____

Submit Your Completed Application *Email, Fax, or Mail to the following:*

Mail: Insurance Company of Scott & White
MS-A4-126
1206 West Campus Drive
Temple, TX 76502

Email: SWHPonline@sw.org
Fax: (254) 298 – 3567

Important: *If any ACH bank draft payment is electronically declined your policy will be terminated in 10 days, if no payment has been received. A new application will be required to obtain future coverage. ACH returns must be paid with certified funds (cashier's check or money order).*

For Office Use Only: Effective Date: _____ Draft Effective Date: _____
Contract ID Number: _____ Phone#: (___) _____ Time: _____ Interviewer: _____