Instructions for Group Enrollment Form

Please complete in black ink

To process your request timely, please be sure the following required fields are provided:

Employer Name	***Group name as listed with Scott & White Health Plan (SWHP)***
Group Number	***First six digits of your division number***
Division Number	***Ten digit number found on your invoice or on the Employer Portal***

Section 1: Requested Action

Indicate the action needed	***New enrollee, termination, change, or cancel = cancel prior to effective date***
Indicate the reason	***New hire/rehire date, birth/adoption date, marriage date or term date***
Submit supporting documents	***Marriage, loss of coverage, or court orders with the application***

IMPORTANT NOTES:

- Avoid delays and/or possible errors in processing by completing all required fields, ensuring form is legible; submit supporting documents with the enrollment form.
- For members terminating coverage and/or employment, Senate Bill 51 applies.

Section 2: Employee Information

Complete entire section	***All information in this section is necessary for accurate and timely processing***
Offering dental or life coverage?	***Select YES or NO if a new employee will be taking the coverage. No other document is needed.***
For employees currently on dental coverage	***If adding or dropping dependents, complete the MetLife Enrollment Form or Change Request Form***

Section 3: Dependent Information

Complete entire section	***Review and complete all applicable information in this section***
Newborn SSN	***Social security number is not necessary to enroll in the plan***
Dependent dental coverage	***Indicate whether dependent will have dental or life coverage***

Section 4: Other coverage

Indicate whether you or your dependents are covered under another group plan	***Review and complete all applicable information in this section***

Section 5: Declination of Coverage

If employee declines coverage	***Fill in the name in Section 1, complete section 5, sign and date. Retain the form for your records only. Form does not need to be sent to SWHP.***
Declination versus Termination	***If an employee is currently enrolled and does not wish to renew coverage, the action requested is a termination, not a declination.***

Section 6: Disclosures

Complete requirement	***This section is a requirement of the Texas Department of Insurance***

Section 7: Acknowledgment Signature

Acknowledgement needed	***Employee needs to read, sign, and date the form acknowledging that they are agreeing to coverage action requested***

Enrollment form submission

Submit the enrollment form in one of the following methods	***Email***	***swhpgroupenrollment@sw.org (Preferred method of return)***
	Fax	***254-298-3199***
	Mail	***Scott & White Health Plan, MS-A4-126, 1206 West Campus Drive, Temple, TX 76502***

SCOTT & WHITE HEALTH PLAN

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ENROLLMENT APPLICATION & CHANGE FORM

Employer Name	
Group Number	
Division Number	

SECTION 1: REQUESTED ACTION		Please check all that apply – Complete section 5 if declining coverage			
√	**New Enrollee**	√	**Termination**	√	**Change**
☐	Open Enrollment	☐	Terminate Coverage (All Members)	☐	Add Dependent(s)
☐	New Hire/Rehire Date (MM/DD/YYYY)	☐	Terminate Dependent(s) Coverage	☐	Change Plan Option
☐	Birth/Adoption Date (MM/DD/YYYY)	☐	Cancel Coverage	☐	Demographic Change(s)
☐	Late Enrollee	☐	Cancel Dependent(s) Coverage		
☐	Marriage Date	Reason:			
☐	Loss of Coverage (Proof of Loss Required)	Term Date:			
☐	Court Order (Provide Court Order or Decree)				

SECTION 2: EMPLOYEE INFORMATION

SSN/Member Number	Prefix	Last Name	First Name	MI	Suffix

Residential Address	Apt. No.	City	State	Zip
Mailing Address (Only if different from above)	Apt. No	City	State	Zip

Primary Phone	Secondary Phone	Email Address

Date of Birth (MM/DD/YYYY)	☐ Male ☐ Female	Primary Care Physician (Optional)	Primary Language: ☐ English ☐ Spanish ☐ Other ___________

Employment Status ☐ Exempt ☐ Non Exempt ☐ Retired	Marital Status ☐ Single ☐ Legally Married ☐ Other
Disability affecting 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

SSN/Member Number	Last Name	First Name	MI	Suffix

Date of Birth (MM/DD/YYYY)	☐ Male ☐ Female	☐ Spouse ☐ Child ☐ Step Child ☐ Grandchild	Primary Care Physician (Optional)
Disability affecting ability to communicate or read? ☐ Yes ☐ No		Primary Language: ☐ English ☐ Spanish ☐ Other	
Dental Coverage? ☐ Yes ☐ No		Life Insurance Coverage? ☐ Yes ☐ No	

DEPENDENT

SSN/Member Number	Last Name	First Name	MI	Suffix

Date of Birth (MM/DD/YYYY)	☐ Male ☐ Female	☐ Child ☐ Step Child ☐ Grandchild	Primary Care Physician (Optional)
Disability affecting ability to communicate or read? ☐ Yes ☐ No		Primary Language: ☐ English ☐ Spanish ☐ Other	
Dental Coverage? ☐ Yes ☐ No		Life Insurance Coverage? ☐ Yes ☐ No	

DEPENDENT

SSN/Member Number	Last Name	First Name	MI	Suffix

Date of Birth (MM/DD/YYYY)	☐ Male ☐ Female	☐ Child ☐ Step Child ☐ Grandchild	Primary Care Physician (Optional)
Disability affecting ability to communicate or read? ☐ Yes ☐ No		Primary Language: ☐ English ☐ Spanish ☐ Other	
Dental Coverage? ☐ Yes ☐ No		Life Insurance Coverage? ☐ Yes ☐ No	

DEPENDENT

SSN/Member Number	Last Name	First Name	MI	Suffix

Date of Birth (MM/DD/YYYY)	☐ Male ☐ Female	☐ Child ☐ Step Child ☐ Grandchild	Primary Care Physician (Optional)
Disability affecting ability to communicate or read? ☐ Yes ☐ No		Primary Language: ☐ English ☐ Spanish ☐ Other	
Dental Coverage? ☐ Yes ☐ No		Life Insurance Coverage? ☐ Yes ☐ No	

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ENROLLMENT APPLICATION & CHANGE FORM

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 the Scott & White Health Plan during my initial eligibility period due to the reason listed below.

☐ I decline enrollment in the Scott & 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 & 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:

Send completed application to:

Email: swhpgroupenrollment@sw.org

-OR-

Fax: 254-298-3199

-OR-

Scott & White Health Plan
MS-A4-126
1206 West Campus Dr.
Temple, TX 76502