Insurance Company of SCOTT&WHITE
PART OF BAYLOR SCOTT & WHITE HEALTH

STUDENT HEALTH COVERAGE
Enrollment Application

Submit by Fax:	**Submit by Email:**
Attention: Student Health Plan **[254-298-3285]** **[254-298-3385]**	**[Nicole.Stevens@BSWHealth.org]**

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. Changes or corrections to this application must be made by drawing a line through the change/mistake and initializing the change. DO NOT use correction tape or fluid.

2. Questions must be answered with complete details given for any "yes" answers. You are responsible for the accuracy and completeness of all information entered on this form. Full disclosure is essential in processing your application. In absence of fraud, all statements made by the applicant shall be deemed representations and not warranties and no statement shall void the coverage or reduce benefits hereunder after your Policy has been in force for two years from its effective date unless it was material to the risk assumed and contained in the Enrollment Application, a completed copy of which has been given to the Subscriber. Health Plan will not rescind based on misstatement of health information, but Health Plan may adjust premium rates if the misstatement concerns tobacco use. In the event of a fraudulent representation, coverage shall terminate immediately. Incomplete applications may result in delays and/or declination. **If more space is needed, attach a separate page(s) and list section(s) and question number(s) then sign and date each page.**

3. All legal-age applicants or the parent/legal guardian of a minor child applicant must personally sign and date this application. If your spouse or any dependent(s) age 18 or over are also applying for coverage, they must personally sign and date this application on the appropriate signature line.

4. Coverage will begin on the 1st of the month and terminate at the end of the month in which you graduate. If the graduation date changes, please notify representative as soon as possible to prevent termination.

5. If you have questions, please contact [Nicole Stevens] at [512-930-6068], Monday through Friday, 8:00 AM – 5:00 PM or email [Nicole.Stevens@BSWHealth.org].

Insurance Company of SCOTT&WHITE
PART OF BAYLOR SCOTT & WHITE HEALTH

Office Use Only: Sales Rep:_____Prem:_____

Application for Student Health Insurance

SECTION 1: APPLICATION INFORMATION

☐New Application ☐Reapplication ☐ Add Member ☐Add Newborn/Adoption
☐Information Change (describe):

SECTION 2: APPLICANT (s) INFORMATION

Primary Applicant's Last Name:	Primary Applicant's First Name:	MI:	Maiden/Other Name:	SS#:

Gender M F Birth date: / /___ Age: Email:

Residential Address:	City:	State:	Zip:
Mailing Address:	**City:**	**State:**	**Zip:**

Home or Cell/ Work phone:	☐Single/Divorced/Widow ☐Legally Married ☐Other:	Do you have a disability which affects your ability to communicate or read? ☐YES ☐NO If "Yes", please describe.	List your primary language:
( ) ( )			

Other Applicants: Legal spouse / dependent children (dependent children must be under age 26).

Spouse Child Adoptee*	Name				Gender	DOB	Age	SS#
	Last:	First:	MI	Maiden/ Other				
Spouse					M☐ F☐	/ /		
Child01					M☐ F☐	/ /		
Child02					M☐ F☐	/ /		
Child03					M☐ F☐	/ /		
Child04					M☐ F☐	/ /		
Child05					M☐ F☐	/ /		
Child06					M☐ F☐	/ /		
Child07					M☐ F☐	/ /		
Child08					M☐ F☐	/ /		

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

SECTION 3: OTHER COVERAGES INFORMATION

1. Has any person applying for coverage currently or previously had Insurance Company of Scott and White coverage, either as a primary insured, spouse or dependent within the last five years? If "Yes", list individual(s) and dates:	Yes☐ No☐
2. Have you or anyone listed on this application had health or major medical coverage (including Medicare or Medicaid) in the last 24 months? If "Yes", please complete the following: Name(s) of all covered:_____ Insurer Name(s):_____ Policy Effective Date: _____ Policy Termination Date: _____	Yes☐ No☐

SECTION 4: TOBACCO USAGE

All Applicants:

Has anyone applying for coverage on this application used tobacco products of any kind regularly (four or more times per week on average, excluding religious or ceremonial uses) within the past six months? ***If "Yes", list which individuals use tobacco regularly, what was used, how long it was used, and, if applicable, the quit date (month/year).***	Yes☐ No☐

SECTION 5: REPLACEMENT COVERAGES INFORMATION

Replacement of Coverage Will this insurance replace any health insurance currently in force? If "Yes", please read the **Notice to Applicant** below and complete the following: List all coverage that will be replaced. Yes☐ No☐

Name(s) of all Insured	Name Of Company	Policy Number	Policy Effective Date	Policy Termination Date	I have read the "**Notice to Applicant**" below.
					Yes☐ No☐

Notice to Applicant

Regarding Replacement of Accident and Sickness Insurance

If "Yes" is indicated above, you intend to lapse or otherwise terminate existing accident and sickness insurance and replace it with a contract to be issued by Insurance Company of Scott & White. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new contract.

A. You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present contract. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.

B. If, after due consideration, you still wish to terminate your present contract and replace it with new coverage, be certain to truthfully and completely answer all questions on this application concerning the medical/health history of any person applying for coverage. After the application has been completed and before you sign it, re-read it carefully to be certain that all information has been properly recorded.

SECTION 6: CERTIFICATION

I understand that coverage with Insurance Company of Scott & White (ICSW) is not automatic. The information provided by me on this application is used by ICSW and is material to its decision to either accept or decline my coverage.

Dental Coverage: The Affordable Care Act (ACA) requires us to be reasonably assured that you and each member on this insurance plan have coverage for pediatric dental services that are essential health benefits. If electing our Dental coverage, all applicants will be covered with an individual premium rate per person.

To select **Dental** or decline dental coverage please select below. For family applications, if you have more than 3 children, only the oldest 3 will be charged for dental premiums. This rule does not apply for child only policies.

☐Add Dental to your coverage (see attached *Rates Sheet*)

☐Decline Dental coverage

Upon review of my application, I will receive notification by mail of my coverage. 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. 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, Print Name of Parent/Guardian and Sign for Dependent(s) Below	Print Name of Primary Applicant **OR** If Child Only Policy, Print Name of Parent/Guardian and 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
Print Name of Dependent	Signature of Parent/Guardian of Dependent	Date

THIS APPLICATION WILL EXPIRE SIXTY (60) DAYS FROM THE ABOVE SIGNATURE DATE

Billing Information

Authorization Agreement for Payments (Insurance Company of Scott & White (ICSW) Student Health Plan):

Insurance Company of Scott & White (ICSW) Student Health 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. Please select your premium payment option below by putting a "check mark" in the appropriate box and then completing the corresponding financial information.

You may change the method of your premium payments by contacting ICSW Customer Service via email at swhp.org or by calling 1-800-321-7947, Monday – Friday, 8:00 AM – 5:00 PM. (Any change in the method of payment will be dependent on the time of month the request is made and the type of payment method requested.)

Purchaser's Information Name (First, Middle, Last & Suffix):

Social Security Number: Relationship to applicant:

Street Address:

City: State: Zip Code:

Email Address: Phone:

Signature: Date:

Initial Payment Option: You will be responsible for paying your first month's premium payment. If an email address was provided, you will receive an email with further instruction on making your initial payment. If an email address was not provided, you will receive a letter.

Ongoing Premium Payment Option: (select 1 of the 3 payment options)

☐**Automatic Bank Draft** *Occurs by the 4th business day of the month. Note: If you have 2 or more types of policies, each will draft separately.*
☐**Paper Invoice** *Pay monthly by check/money order*
☐**Pay Online** ***payments are made by you*** *by going to the* ***www.swhp.org*** *web site*

Automatic Bank Draft information*: Occurs by the 4th business day of the month*

☐Checking Account ☐Savings Account

Name of Financial Institution:

Account Number: Routing Number:

Name on Account:

Authorized Signature for Account: Date:

Contract Holder: Print Name:

Signature: Date:

Important: If your initial payment by Credit/Debit Card is electronically declined, your policy will not be issued. If an ongoing ACH bank draft payment is electronically declined your policy will be terminated back to the first of the month in which the draft was declined. A new application will be required to obtain future coverage. ACH returns must be paid with certified funds (cashier's check or money order). Any amount not paid by your financial institution will be assessed a $30 fee.

Send Completed Application Attn: Marketing Department

Email your signed application to:
[Nicole.Stevens@BSWHealth.org]

OR

Fax your signed application to:
[254-298-3285]