SWHP Employer Portal
Access Request

Please complete this form if you would like to access the Scott and White Health Plan Employer Portal.

Requestor's information:

School District:	
First Name:	
Last Name:	
Email:	
Phone Number:	
Date of Birth:	Last 4 of Social Security Number:

New user information:

School District:	
First Name:	
Last Name:	
Email:	
Phone Number:	
Date of Birth:	Last 4 of Social Security Number:

School District:	
First Name:	
Last Name:	
Email:	
Phone Number:	
Date of Birth:	Last 4 of Social Security Number:

Please sign and date this Agreement in the space provided below to confirm your agreement to these terms and conditions, then submit. By typing your name into this form, you are signing this Agreement electronically.

Title: _____

Signature: _____

Date: _____

Submit

Note that anyone with access to the Employer Portal could have access to member PHI. You agree your electronic signature is the legal equivalent of your manual signature on this Agreement. You also agree that no certification authority or other third party verification is necessary to validate your E-Signature and that the lack of such certification or third party verification will not in any way affect the enforceability of your E-Signature or any resulting agreement between you and Scott and White Health Plan.