INSURANCE COMPANY OF
Scott&White
PART OF BAYLOR SCOTT & WHITE HEALTH

Employer Name	
Group/Division #	
Dental/Division #	
Life/Division #	

(Mandatory

Group Enrollment PPO/EPO Application & Change Form

Send completed application by one of the following methods:		
Email	**Fax**	**Mail**
SWHPGroupEnrollment@bswhealth.org **Subject line: Group Name/Group Number/Division**	Fax 254-298-3199	Scott and White Health Plan MS-A4-126 1206 West Campus Drive Temple, TX 76502

SECTION 1: REQUESTED ACTION - Check all the boxes that apply and complete the additional sections that correspond to your selection.

Please allow 5 business days for processing. To prevent delays, please send your completed enrollment form directly to swhpgroupenrollment@BSWHealth.org Avoid delays and/or possible errors in processing by completing all required fields, legibly.
Applications received without proper documentation will **not** be processed.
Hire Date is mandatory on all new enrollees and open enrollment elections.
For members terminating coverage and/or employment, coverage remains in effect through the end of the month in which notice was provided.
Late enrollees are not eligible for coverage until the next Open Enrollment Period. Please refer to your explanation of coverage (EOC).
If enrolling outside of the open enrollment period, you must have a qualifying event in order to be eligible.

If declining coverage, complete Section 2 and 6
(If an employee is currently enrolled and does not wish to renew, the action to request is a termination, not a declination.)

Enrollment Event – Check ALL boxes that apply.

❑ **Open Enrollment** ❑ **New Hire**	**Date of Hire (MM/DD/YYYY)**	**Qualifying Event? ❑ Yes ❑ No** ***Select the appropriate event and enter event date.***		**Termination/Cancellation** **Termination Date (MM/DD/YYYY)**
❑ **Rehire**	**Date of Rehire (MM/DD/YYYY)**	❑ **Birth/Adoption** **Proof of Adoption Required**	**Date of birth/adoption**	❑ **Terminate Contract** ***(Enrollee and all dependents)*** ❑ **Medical** ❑ **Dental** ❑ **Life**
Other Changes ❑ **Add Dependent(s)** ❑ **Change Plan Option** ❑ **Demographic Change(s)**		❑ **Marriage** **Proof of Marriage Required**	**Date of marriage**	❑ **Terminate Dependent(s) Coverage** ***Complete Sections 4, 5, and 6***
		❑ **Loss of Coverage** **Proof of Loss Required**	**Date coverage ended**	**Reason for Termination** ❑ **Termination of Employment** ❑ **Retirement** ❑ **Termination of Benefits** ❑ **Other** ❑ **Death** **Date of Death**
		❑ **Court Order** **Court Order or Decree Required**	**Date of order**	

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SECTION 2: DECLINATION OF COVERAGE

Retain the form for your records only. The form does not need to be sent to SWHP for current groups. Waivers are required for new group submissions. If an employee is currently enrolled and does not wish to renew coverage, the action requested is a termination, not a declination.

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 or 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 become party to a suit to adopt, you may enroll yourself and your dependents, provided that you request enrollment within 31 days after the qualifying event.

☐ I decline enrollment in Scott and White Health Plan during my initial eligibility period due to the reason listed below. (**employee)**

☐ I decline enrollment in Scott and 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 reason for declining coverage (please specify):

I have not been discouraged by Group or Health Plan from enrolling for coverage.

SECTION 3: 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 4: EMPLOYEE INFORMATION – All information in this section is necessary for accurate and timely processing.

Coverage Selection **Medical** ☐ Add ☐ Term ☐ Change ☐ No Change	**Dental** ☐ Add ☐ Term ☐ Change ☐ No Change	**Life** ☐ Add ☐ Term

Social Security Number	First Name	MI	Last Name	Suffix

Residential Address	Apt	City	State	Zip
Mailing Address (If different than above)	**Apt**	**City**	**State**	**Zip**

Primary Phone	Secondary Phone	Email Address	Preferred Method ☐ Email ☐ Mail

Employment Status ☐ Exempt ☐ Non Exempt ☐ Retired	Marital Status ☐ Single/Divorced/Widow ☐ Married ☐ Other	☐ Male ☐ Female	Date of Birth (MM/DD/YYYY)

Primary Spoken Language ☐ English ☐ Spanish ☐ Other (please indicate)	Written Language ☐ English ☐ Spanish ☐ Other (please indicate)

Do you have a disability affecting your ability to communicate or read? ☐ Yes ☐ No

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SECTION 5: DEPENDENT INFORMATION – Complete all applicable information in this section.

List all family members
Please complete every field in its entirety to ensure correct processing.

Medical ❑ Add ❑Term ❑ Demographic Change ❑ No Change	First Name	MI	Last Name	Suffix
	Social Security Number	❑ Male ❑Female	Date of Birth (MM/DD/YYYY)	
Dental ❑ Add ❑Term ❑ Demographic Change ❑ No Change	Primary Language Spoken:❑ English ❑ Spanish ❑Other_____ Written❑ English ❑ Spanish ❑Other_____		❑ Spouse ❑Child ❑ Grand Child ❑ Other Eligible Dependent_____	
	Disability affecting your ability to communicate or read? ❑Yes ❑No			

Medical ❑ Add ❑Term ❑ Demographic Change ❑ No Change	First Name	MI	Last Name	Suffix
	Social Security Number	❑ Male ❑Female	Date of Birth (MM/DD/YYYY)	
Dental ❑ Add ❑Term ❑ Demographic Change ❑ No Change	Primary Language Spoken: ❑ English ❑Spanish ❑Other_____ Written: ❑English ❑Spanish ❑Other_____		❑ Spouse ❑Child ❑ Grand Child ❑ Other Eligible Dependent_____	
	Disability affecting your ability to communicate or read? ❑Yes ❑No			

Medical ❑ Add ❑Term ❑ Demographic Change ❑ No Change	First Name	MI	Last Name	Suffix
	Social Security Number	❑ Male ❑Female	Date of Birth (MM/DD/YYYY)	
Dental ❑ Add ❑Term ❑ Demographic Change ❑ No Change	Primary Language Spoken: ❑English ❑Spanish ❑Other Written:❑English ❑Spanish ❑Other		❑ Spouse ❑Child ❑ Grand Child ❑ Other Eligible Dependent_____	
	Disability affecting your ability to communicate or read? ❑Yes ❑No			

Medical ❑ Add ❑Term ❑ Demographic Change ❑ No Change	First Name	MI	Last Name	Suffix
	Social Security Number	❑ Male ❑Female	Date of Birth (MM/DD/YYYY)	
Dental ❑ Add ❑Term ❑ Demographic Change ❑ No Change	Primary Language Spoken: ❑English ❑Spanish ❑Other Written: ❑English ❑Spanish ❑Other		❑ Spouse ❑Child ❑ Grand Child ❑ Other Eligible Dependent	
	Disability affecting your ability to communicate or read? ❑Yes ❑No			

Medical ❑ Add ❑Term ❑ Demographic Change ❑ No Change	First Name	MI	Last Name	Suffix
	Social Security Number	❑ Male ❑Female	Date of Birth (MM/DD/YYYY)	
Dental ❑ Add ❑Term ❑ Demographic Change ❑ No Change	Primary Language Spoken: ❑English ❑Spanish ❑Other Written: ❑English ❑Spanish ❑Other		❑ Spouse ❑Child ❑ Grand Child ❑ Other Eligible Dependent	
	Disability affecting your ability to communicate or read? ❑Yes ❑No			

SECTION 6: 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 Insurance Company of Scott and White 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.

☐ **I HAVE READ AND ACCEPT THE BELOW AGREEMENT**

I understand that the Certificate of Coverage, Explanation of Benefits, and other required documents, notices, and communications may be mailed or transmitted electronically to me. By checking this box, I am consenting to the electronic delivery of these communications. If the box is not selected I will receive paper communications. Consent may be withdrawn at any time by contacting the Health Plan at 800-321-7947. If consent is withdrawn, paper documents will be provided during the policy benefit period.

Signature	Print Name	Date (MM/DD/YYYY)

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Nondiscrimination Notice

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-321-7947 (TTY: 711).

Insurance Company of Scott and White complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Insurance Company of Scott and White does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Insurance Company of Scott and White:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Written information in other formats (large print and accessible electronic formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Insurance Company of Scott and White Compliance Officer at 1-214-820-8888 or send an email to SWHPComplianceDepartment@BSWHealth.org

If you believe that Insurance Company of Scott and White has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Insurance Company of Scott and White, Compliance Officer
1206 West Campus Drive, Suite 151
Temple, Texas 76502

Compliance HelpLine; 1-888-484-6977 or https://app.mycompliancereport.com/report.aspx?cid=swhp

You can file a grievance in person or by mail, online, or email. If you need help filing a grievance, the Compliance Officer is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 1-800-537-7697 (TDD)

Complaint forms are available at https://www.hhs.gov/civil-rights/filing-a-complaint/index.html.

Language Assistance/ Asistencia de idiomas

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English:
ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-321-7947 (TTY: 711).

Spanish:
ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-321-7947 (TTY: 711).

Vietnamese:
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-321-7947 (TTY: 711).

Chinese:
注意：如果 使用繁體中文, 可以免費獲得語言援助服務。請致電 1-800-321-7947 (TTY：711)。

Korean:
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-321-7947 (TTY: 711) 번으로 전화해 주십시오.

Arabic:
هاتف الصم والبكم: 711 .ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-321-7947 (رقم

Urdu:
1-800-321-7947 (TTY: 711) خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کریں.

Tagalog:
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-321-7947 (TTY: 711).

French:
ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-321-7947 (ATS : 711).

Hindi:
ध्यान दें: यदिआप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध है। 1-800-321-7947 (TTY: 711) पर कॉल करें।

Persian:
فراهم می باشد. با 1-800-321-7947 (TTY: 711) تماس بگیرید. توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما

German:
ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-321-7947 (TTY: 711).

Gujarati:
સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-800-321-7947 (TTY: 711).

Russian:
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-321-7947 (телетайп: 711).

Japanese:
注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-321-7947 (TTY:711) まで、お電話にてご連絡ください。

Laotian:
ໂປດຊາບ: ຖ້າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍ ລິການຊ່ ວຍເຫ ຼືອດ້ ານພາສາ, ໂດຍບໍ ່ເສັ ຽຄ ່າ, ແມ ່ນມ ີພ້ ອມໃຫ ້ທ ່ານ. ໂທຣ 1-800-321-7947 (TTY: 711).