Primary Applicant's Last Name	Applicant's Social Security Number
Agent Name	Agent NPN

Home Office Use ONLY	Eff Date:

HMO Application Instructions *(Health Maintenance Organization)*

TEXAS DEPARTMENT OF INSURANCE REQUIRED DISCLOSURE NOTICE FOR ALL INDIVIDUAL HMO CONSUMER CHOICE BENEFIT PLANS ISSUED IN TEXAS

Applicable if selecting a Consumer Choice Health Benefit Plan

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 plan 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.

To help us process your application promptly, please remember to:

- Print all answers in **black ink** legibly. Pencil will not be accepted.
- Make sure to personally sign the application as the Primary Applicant. Anyone over the age of 18 applying for coverage must sign the appropriate signature line (unless parent has Power of Attorney).
- If it is necessary to correct any errors, simply cross off what is incorrect and write initials next to the correct information.
- Please do not use correction fluid or tape.
- If more space is needed, attach separate page(s) and list section(s) and question number(s), then sign and date each page.
- If you have been covered by SWHP, or an affiliated company, within the past 12 months and the evidence of coverage was terminated for nonpayment of premium, you will be required to pay the past due amount and the initial premium for the new coverage before your evidence of coverage will be effective

Please submit an application via one of the following methods:

- Mail: Scott and White Health Plan, Attention: Enrollment, 1206 West Campus Dr., MS-A4-126, Temple, TX 76502
- Fax: (254) 298-3199
- Email: swhpElectronicEnrollment@bswhealth.org

If you have any questions, please call your agent or an Internal Sales Specialist at (866) 522-2515.

OPEN ENROLLMENT (OE): November 1 – December 15 Submission Dates

Application received prior to the end of Open Enrollment	Effective date will be January 1

SEP ENROLLMENT (SEP): Year Round Submission Dates

If applying outside of Open Enrollment, you must have experienced one of the events below (during the last 60 days) in order to apply. Please answer the following questions only if applying for a Special Enrollment Period.	
Requested Effective Date	
☐ I and/or my dependent(s) lost Minimum Essential Coverage: (Choose one of the two options)	
☐ Involuntary loss of Minimum Essential Coverage (example: losing group coverage, divorce & aging off parents plan at age 26)	Date of Event
☐ Losing or replacing current Scott and White Health Plan or Insurance Company of Scott and White? ***If yes, please provide the plan identification number(s):_____***	Date Coverage Ends
☐ Birth, Adoption, placement for adoption or foster care or become a party to a suit to adopt *(Effective date will be date of birth or date of adoption/placement)*	Date of Event
☐ Relocation to a new service area	Date of Event
☐ Marriage or gaining dependent due to marriage	Date of Event
☐ Gaining Citizenship	Date of Event
☐ Release from incarceration	Date of Event
Send all SEP supporting documents to: swhpelectronicenrollment@bswhealth.org or fax to 254-298-3199. Applications submitted for a Special Enrollment Period will not be processed without supporting documentation.	

Primary Applicant's Last Name	Applicant's Social Security Number
Agent Name	Agent NPN

Home Office Use ONLY	Eff Date:

HMO Enrollment Application

(Health Maintenance Organization)

SECTION 1: PRIMARY APPLICANT (If Purchaser is different than Primary Applicant, include Purchaser's information in Section 8)

First Name	MI	Last Name	Suffix

**** Social Security Number	Date of Birth (MM/DD/YYYY)	Age *	◯Male ◯Female	Within the past 6 months, have you used tobacco 4 or more times per week on average? ◯Yes ◯No

Marital Status ◯ Single/Divorced/Widow ◯ Married ◯ Other__________________ | Are you a US citizen or US national? ◯ Yes ◯ No

Race (optional- check only one) ◯ White ◯ Black/African American ◯ Hispanic/Latino ◯ American Indian/Alaska American ◯ Asian Indian ◯ Chinese ◯ Filipino ◯ Japanese ◯ Korean ◯ Vietnamese ◯ Other Asian ◯ Native Hawaiian ◯ Guamanian/Chamorro ◯ Samoan ◯ Pacific Islander ◯ Other

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

Primary Phone Cell ◯ Landline ◯	Secondary Phone Cell ◯ Landline ◯
Email Address	Preferred Contact Method ◯ Email ◯ Mail

Primary Language:
◯ English ◯ Spanish ◯ Other (Please Specify):______________________

*** Apply for Dental Coverage? ◯ Yes ◯ No

Do you have a disability affecting your ability to communicate or read? ◯ Yes ◯ No
If yes, please explain______________________________________

SECTION 2: DEPENDENT INFORMATION

DEPENDENT

First Name	MI	Last Name			Suffix
**** Social Security Number	Date of Birth (MM/DD/YYYY)	Age *	Relationship ◯ Spouse ◯ Child	◯ Male ◯ Female	Tobacco Use** ◯ Yes ◯ No
Are you a US citizen or US national? ◯ Yes ◯ No			*** Apply for Dental Coverage? ◯ Yes ◯ No		

DEPENDENT

First Name	MI	Last Name			Suffix
**** Social Security Number	Date of Birth (MM/DD/YYYY)	Age *	Relationship ◯ Spouse ◯ Child	◯ Male ◯ Female	Tobacco Use** ◯ Yes ◯ No
Are you a US citizen or US national? ◯ Yes ◯ No			*** Apply for Dental Coverage? ◯ Yes ◯ No		

DEPENDENT

First Name	MI	Last Name			Suffix
**** Social Security Number	Date of Birth (MM/DD/YYYY)	Age *	Relationship ◯ Spouse ◯ Child	◯ Male ◯ Female	Tobacco Use** ◯ Yes ◯ No
Are you a US citizen or US national? ◯ Yes ◯ No			*** Apply for Dental Coverage? ◯ Yes ◯ No		

DEPENDENT

First Name	MI	Last Name			Suffix
**** Social Security Number	Date of Birth (MM/DD/YYYY)	Age *	Relationship ◯ Spouse ◯ Child	◯ Male ◯ Female	Tobacco Use** ◯ Yes ◯ No
Are you a US citizen or US national? ◯ Yes ◯ No			*** Apply for Dental Coverage? ◯ Yes ◯ No		

*Age as of Effective date

***Within the past 6 months, have you used tobacco 4 or more times per week on average?*

***The Affordable Care Act (ACA) requires us to be reasonably assured that you and each member on this evidence of coverage have or are seeking coverage for pediatric dental services that are Essential Health Benefits.

****If someone needs help getting a SSN, call (800)772-1213 or visit socialsecurity.gov. TTY users should call (800)325-0778

Primary Applicant's Last Name	Applicant's Social Security Number
Agent Name	Agent NPN

SECTION 3: CHOOSE YOUR COVERAGE

☐ Select ACA Ind HMO Bronze 7500		

SECTION 4: DENTAL ACKNOWLEDGEMENT

The Affordable Care Act ("ACA") requires us to be reasonably assured that you and each member on this evidence of coverage have or are seeking coverage for Pediatric Dental Services that are Essential Health Benefits.

To choose Dental coverage for one or all members on plan, choose appropriate boxes on page 2 of application, sections 1 and/or 2.
If **declining** Dental coverage, your signature in section 7 will verify you have obtained coverage for Pediatric Dental Essential Health Benefits (dependents 0-18 years old) through another policy.

Prices for Dental Coverage for each member of evidence of coverage are:

Ages 0-18 years	$36.28/month per member
Ages 19 years and over	$31.88/month per member

NOTE: You will receive a separate ID number for Dental Policies. Premium for Dental must be paid separately from Medical.

DEDUCTIBLES Section 11.506(2)(B), Subchapter F, Title 28 Texas Insurance Code
Applicable to Consumer Choice Health Benefit Plans

A deductible shall be for specific dollar amount of the cost of the basic, limited or single health care service. An HMO shall charge a deductible only for services performed out of the HMO's service area or for services performed by a physician or provider who is not in the HMO's delivery network.

Deductibles may apply to some services provided by HMO Participating Providers in the HMO service area. Deductibles may apply to Professional Services, Inpatient Hospital Services, Outpatient Facility Services, Outpatient Lab and X-Ray Services, Rehabilitation Services, Maternity Care and Family Planning, Behavioral Health Services, Emergency and Ambulance Services, Extended Care Services, some Preventive Care Services, Dental Surgical Procedures, Cosmetic, Reconstructive or Plastic Surgery, Allergy Care, Diabetes Care, Prosthetic Appliances, Orthotic Devices, Durable Medical Equipment, Hearing Aids and Prescription Drugs.

ATTENTION FEMALE MEMBERS: In selecting your PCP, remember that your PCP's network may affect your choice of OB/GYN. You have the right to receive services from an OB/GYN without first obtaining a referral from your PCP. You are not required to designate an OB/GYN. You may elect to receive OB/GYN services from your PCP.

Name of preferred OB/GYN : (Please note that you may change your selection at any time)

SECTION 5: REPLACEMENT COVERAGE INFORMATION

Will this insurance replace any current health insurance plan or evidence of coverage with Scott and White Health Plan or Insurance Company of Scott and White?

◯ Yes ◯ No

If you have been covered by SWHP, or an affiliated company, within the past 12 months and the evidence of coverage was terminated for nonpayment of premium, you will be required to pay the past due amount and the initial premium for the new coverage before your evidence of coverage will be effective.

If yes, please provide the plan or evidence of coverage number(s):	Date Coverage Ends:

Primary Applicant's Last Name	Applicant's Social Security Number
Agent Name	Agent NPN

SECTION 6: Agent Information (If applicable)		
Agent's Certification: I certify that I sent the application to the Applicant(s) for completion, or I personally asked the questions and recorded the answers as given. I further certify that I have no knowledge of any other medical information about the Applicant(s) not contained in this application and that written material explaining the benefits, exclusions and provisions of the Contract was sent to the Applicant(s). I certify that I have delivered the required Outline of Coverage, and if requested, the Disclosure Statement. **Third-Party payments will not be accepted for ACA plans, except those required by Federal guidance. (This would include Employer payments for Employee coverage, Company checks unless Sole Proprietorship, Provider payments and Foundation payments. Payments for family members or Family Trusts are not considered a Third-Party payment.)**		
Agent's Signature	Date (MM/DD/YYYY)	Agent's NPN
Print Agent's Name	Agent's Phone	

SECTION 7: CERTIFICATION	
I understand the initial monthly premium payment must be paid in advance prior to the issuance of a plan. SWHP will not approve or deny my application on any basis which is prohibited by law. If declining Pediatric Dental coverage (on page 2, sections 1 and/or 2), I understand I must obtain coverage for Pediatric Dental Essential Health Benefits (dependents 0-18 years old) through another policy. 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 valid as the original. **Third-Party payments will not be accepted for ACA plans, except those required by Federal guidance. (This would include Employer payments for Employee coverage, Company checks unless Sole Proprietorship, Provider payments and Foundation payments. Payments for family members or Family Trusts are not considered a Third-Party payment.)**	
Primary Applicant's Signature (or Parent/Guardian if Child Only Plan) X	Date (MM/DD/YYYY)
Spouse's Signature X	Date (MM/DD/YYYY)
Dependent's Signature (Only if 18 or over and to be insured) X	Date (MM/DD/YYYY)
Dependent's Signature (Only if 18 or over and to be insured) X	Date (MM/DD/YYYY)
Dependent's Signature (Only if 18 or over and to be insured) X	Date (MM/DD/YYYY)

Primary Applicant's Last Name	Applicant's Social Security Number
Agent Name	Agent NPN

SECTION 8: BILLING INFORMATION

Purchaser's Information (If different than Primary Applicant)

First Name	MI	Last Name	Suffix

Relationship to Applicant	Mailing Address	City	State	Zip

Signature	Date

Third-Party payments will not be accepted for ACA plans, except those required by Federal guidance. (This would include Employer payments for Employee coverage, Company checks unless Sole Proprietorship, Provider payments and Foundation payments. Payments for family members or Family Trusts are not considered a Third-Party payment.)

INITIAL PAYMENT

Upon receipt of Welcome email and/or letter, you must make a payment by one of the following to activate your coverage:

- Member portal located at https://portal.swhp.org/#/registration-1
- e-PAY (877)729-3763
- Mail check to: SWHP, PO Box 846035, Dallas, TX 75284-6035
- Contact Customer Service at (800)321-7947

Important: If initial payment by Credit/Debit Card is electronically declined, coverage will not be issued. If an ongoing ACH bank draft payment is electronically declined, your coverage 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 (pending Special Enrollment Period qualification). Any amount not paid by your financial institution will be assessed a $30 fee.

If you have been covered by SWHP, or an affiliated company, within the past 12 months and the evidence of coverage was terminated for nonpayment of premium, you will be required to pay the past due amount and the initial premium for the new coverage before your evidence of coverage will be effective

ONGOING PAYMENTS (MUST COMPLETE)

- ◯ Automatic Bank Draft (complete EFT information below)
- ◯ Monthly Billing Statement (paper)
- ◯ Pay Online at https://portal.swhp.org/#/registration-1 (requires registration in member portal)

AUTOMATIC BANK DRAFT (First month's initial premium MUST be made manually. Bank Draft will go into effect Second month)

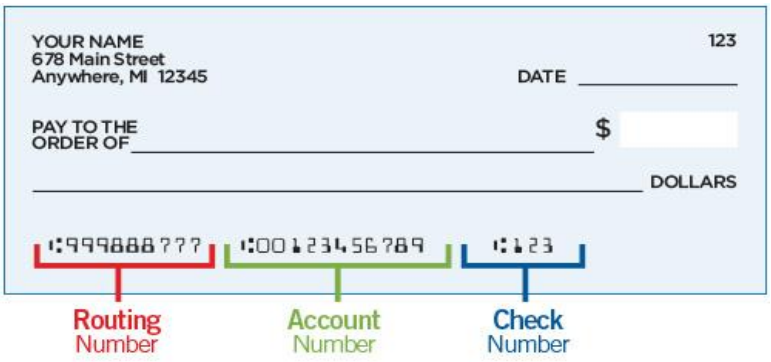
◯ Checking
◯ Savings

Name of Bank

Routing Number

Account Number

Name on Account



Authorized Signature for Account	Date

Terms of Agreement: My account at the institution named above has sufficient funds to pay all debits and charge credits. SWHP shall activate electronic debit, charge or credit entries to pay premiums/charges for authorized plan, and the entries are my transaction receipt. I understand that by electing Automatic Bank Draft and with my signature in ONGOING PAYMENT section above, I am accepting the terms of the ONGOING PAYMENT Agreement. **NOTE: SWHP will not process Auto Bank Draft until month following receipt of the initial premium payment to activate coverage.**

REQUIRED DISCLOSURE NOTICE FOR ALL INDIVIDUAL CONSUMER CHOICE

BENEFIT PLANS ISSUED IN TEXAS

As required by 28 TAC §21.3530, I have been informed that the Consumer Choice Standard Benefit Plan that I am purchasing does not include all state mandated health benefits. I understand that the following benefits are provided at a reduced level from what is mandated, or are excluded completely from the plan:

Mandated Benefit Description	Benefit Reduced	Benefit Excluded
28 TAC 11.506(2)(B) - Deductibles	X	

This HMO Consumer Choice Health Benefit Plan may include requirements and/or restrictions on deductibles, coinsurance, copayments, or annual or lifetime maximum benefit amounts that differ from other HMO plans. I understand that I may obtain from the Department of Insurance a consumer brochure with more information on Consumer Choice Health Benefit Plans, either by visiting the TDI website at www.tdi.texas.gov, or by calling 1 -800-252-3439. I also affirm that at the same time I was offered this Consumer Choice Benefit Plan, I was offered a plan that contained all state mandated health benefits.

Name of Applicant	Signature of Applicant		
Name of Business (if applicable)		Date	
Address	City	State	Zip

Note: This form must be retained by the carrier issuing the evidence of coverage and must be provided to the Commissioner of Insurance upon request. **You have the right to a copy of this written disclosure statement free of charge.** A new form must be completed upon each subsequent renewal of this policy.

Post Enrollment Instructions

Welcome to Scott and White Health Plan. Please keep this page to use as a reference guide for your application process. Thank you for applying. We look forward to servicing your healthcare needs.

SECTION 9: NEXT STEPS	
1	If applying for Open Enrollment, proceed to Step 3 below:
2	If applying for Special Enrollment: **Please send all SEP supporting documents to: swhpelectronicenrollment@bswhealth.org or fax to 254-298-3199. Applications submitted for Special Enrollment Period will not be processed without supporting documentation.**
3	Wait approximately 5-7 business days to receive a response via email and/or letter from SWHP, giving instructions for making the initial premium payment.
4	To make **initial** payment: • Login to member portal at https://portal.swhp.org/#/registration-1 (If you do not have your member number yet, you can search by Social Security Number and date of birth) • Call e-PAY line at (877) 729-3763 • Mail check to: SWHP, PO Box 846035, Dallas, TX 75284-6035 • Contact Customer Service at (800) 321-7947
5	After initial payment is made, the payment takes 24-48 hours to post to your account. Once payment is posted, your **ID Card** will generate and be mailed to you. Please allow 7-10 days after payment has posted to receive your **ID Card** by mail. You can also print a temporary card from your member portal once payment has posted. Check ID Card to make sure all insured members are listed on card.

IMPORTANT INFORMATION	
Customer Service	(800) 321-7947
Member Portal	https://portal.swhp.org/#/registration-1 Need Social Security Number **OR** Member ID Number & Date of Birth to register Secure messaging can be sent through your member portal to departments and receive quick responses.
Contract ID # vs Member ID #	Contract ID # is first 9 digits of Member ID # (Example: *Contract # is 123456789)* Member ID # is 11 digits *(Example: Member # 12345678900)* Each member on the contract will have sequential numbering as the suffix: *(Example: -00, -01, -02, -03 for Contract holder plus 3 dependents)*
Dental	Member will have a separate Dental ID # if dental coverage was chosen, and the dental premium must be paid separate from the medical premium. Member will not receive a Dental ID Card. Dental offices will verify benefits with the contract holder's Social Security Number. **Locate Dental Provider:** https://metlocator.metlife.com/metlocator/execute/Search (PDP Plus Network Provider)
Note regarding the cancellation of existing coverage: It is best that applicant not cancel any coverage until receiving confirmation of acceptance from SWHP.	

(Attach Agent Business Card Here)

AGENT'S INFORMATION
Print Agent's Name
Agent's Phone

Scott&White
HEALTH PLAN
PART OF BAYLOR SCOTT & WHITE HEALTH

Nondiscrimination Notice

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

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

Scott and White Health Plan:

- 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 Scott and White Health Plan (SWHP) Compliance Officer at 1-214-820-8888 or send an email to SWHPComplianceDepartment@BSWHealth.org

If you believe that Scott and White Health Plan 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:

SWHP 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 SWHP 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

Scott&White HEALTH PLAN
PART OF BAYLOR SCOTT & WHITE HEALTH

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:
خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال 1-800-321-7947 (TTY: 711). 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: यदि आप 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 નિઃશુલ્ક 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 ທ່ານ ເວົ້າ ພາສາ ລາວ, ການ ບໍ ລິ ການ ຊ່ ວຍ ເຫ ຼືອ ດ້ ານ ພາສາ, ໂດຍ ບໍ ່ ເສັ ຽ ຄ່ າ, ແມ ່ ນ ພ ້ ອມ ໃຫ ້ ທ ່ ານ. ໂທ 1-800-321-7947 (TTY: 711).