Memorial Hermann Enrollment Kit
PPO

General Info

Producer:		Email:	
Phone:		Fax:	
Group Name:		Effective:	

Submission Checklist

	document/item	doc #	revised
☐	**Sold Group Checklist**	n/a	04-14
☐	**Employer Group Application** – *Signed by Employer*	706217F	01-17
☐	**Data Submission Agreement** – *Signed by Employer*	n/a	11-14
☐	**COBRA and Medicare Survey** – *Required to ensure compliance with state and federal laws. Completed and signed by Employer.*	703860	07-13
☐	**Common Ownership Certification Form** - *Required*	n/a	12-14
☐	**Auto-Draft Premium Authorization Form** – *Optional*	705559	01-15
☐	**Most recent Quarterly Wage & Tax Statement** – *Signed/dated or copy of electronic validation*		
☐	**First month's premium check payable to Memorial Hermann Health Insurance Co**		
☐	**Last billing statement from current carrier**		
☐	**Original Proposal** – *Last page (Acceptance Agreement) of quote completed and signed by employer.*		
☐	**Employee Applications** – *Required for all enrolling subscribers. Spreadsheet Enrollment also available*	706216	06-17

Broker Checklist

☐ Are all employees accounted for?

☐ Broker appointment with MHHIC?

☐ Group meet/exceed participation requirement?

Contact

Submit Paperwork to
Kilpatrick Companies, LLC
1050 Wilcrest Dr.
Houston, TX 77042

Call
800-833-8478

Internet
www.kilpatrickcos.com

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Kilpatrick COMPANIES

MEMORIAL HERMANN
Health Insurance Co

THANK YOU FOR YOUR BUSINESS!

Broker Name____________________________ Agency____

Phone Number:_____________ Email:___________________ MHHIC Sales Director_______________

Group Name ____

Effective Date _____________________Group Contact Name ____________________________________

Contact for questions:____

Ph# ___________________________ Email:____

ALL COMPLETED ORIGINAL DOCUMENTS DUE IN MEMORIAL HERMANN HEALTH INSURANCE COMPANY (MHHIC) SALES OFFICE BY THE 5TH OF THE MONTH

SALES @ Memorial Hermann Health Insurance Company, 929 Gessner, Suite 1500, Houston, TX 77024

SOLD GROUP CHECK-OFF LIST

☐ 1. **Broker MHHIC Appointment complete or "in process"**

☐ 2. Completed Group Employer Application Signed by Group and Agent
*Must include **Federal** Tax Identification Number (TIN) on form.*

☐ 3. First month's premium check made out to Memorial Hermann Health Insurance Co.

☐ 4. Copy of the most recent Wage and Tax Report filed with TWC and/or C3 identifying current employment status of each employee (FT/PT/Seasonal/Termed)

☐ 5. Completed and signed Employee Applications or Spreadsheet for all enrolling employees

- Number of EE's:_____________ Number of total members:______________

☐ 6. Signed Waivers→ Number Declining:__________ Number Waving O/C:_____________

☐ 7. Verify 75% participation requirement (Small Group only)

☐ 8. Copy of the latest billing statement from prior carrier (**Name**)______________________

☐ 9. MHHIC COBRA and Medicare Questionnaire

☐ 10. ACH Auto-Draft Form for Group Premium (not required)

☐ 11. Copy of Sold Quote Signed by Group

☐ **12. Final Proposal with correct enrollment and plan(s) chosen on signed Acceptance Page**

NOTE: Please provide documentation for any applicable Deductible Credit (EOB or Report from Prior Carrier) as soon as possible to Memorial Hermann Health Insurance Company group Account Executive

MEMORIAL HERMANN
Health Insurance Co

Medical Coverage underwritten by Memorial Hermann Health Insurance Company

GROUP EMPLOYER APPLICATION
SMALL GROUP METAL PLANS

FOR Memorial Hermann Health Insurance Company ("MHHIC") USE ONLY		
GROUP NO.	UNDERWRITER NO.	EFFECTIVE DATE

1. EMPLOYER INFORMATION – The employer certifies the following information.

COMPANY OR EMPLOYER NAME			
STREET ADDRESS (P.O. Box not acceptable)	CITY	STATE	ZIP
BILLING ADDRESS	CITY	STATE	ZIP

EMPLOYER IS
☐ Corporation ☐ Partnership ☐ Sole Proprietorship ☐ Other-Explain:

COMPANY CONTACT PERSON	PHONE NO. ( )	FAX NO. ( )

DATE COMPANY WAS ESTABLISHED (Mo/Yr)	TYPE OF BUSINESS (Be specific)	E-MAIL ADDRESS	SIC CODE

Has the Company been insured by MHHIC in the last 12 months? .... ☐ Yes ☐ No If yes, date prior MHHIC coverage terminated: ____________________

Has the Employer filed for bankruptcy in the past seven years? .... ☐ Yes ☐ No Tax Identification Number (TIN) ________________________________

Has the Employer been without group health coverage for at least 2 months prior to the requested Effective Date?"....... ☐ Yes ☐ No

2. MEDICAL COVERAGE SELECTION - Metal Plans

Platinum ☐ Select Platinum 500 PPO

Gold
- ☐ Select Gold 1000 PPO
- ☐ Select Gold 1500 PPO
- ☐ Select Gold 2000 PPO
- ☐ Select Gold 2000-3500 PPO
- ☐ Select Gold Copay PPO

Silver
- ☐ Select Silver 3000 PPO
- ☐ Select Silver 4500 PPO
- ☐ Select Silver 5000 PPO
- ☐ Select Silver 4000 HSA PPO

Bronze
- ☐ Select Bronze 6850 PPO
- ☐ Select Bronze 5000 HSA PPO
- ☐ Select Bronze 6550 HSA PPO

3. ADDITIONAL RIDERS

IN·VITRO FERTILIZATION RIDER ☐ Add rider ☐ Decline rider ☐ N/A

PLEASE NOTE: In-Vitro Fertilization benefits MUST be offered consistently across all plan selections.

FOR MHHIC USE ONLY					
DATE APPROVED	EFFECTIVE DATE	DATE REJECTED	PRODUCT CODE	GROUP TYPE	UNDERWRITING POINTS

4. EMPLOYER CONTRIBUTION

4A. EMPLOYER MEDICAL CONTRIBUTION OPTION

☐ Traditional Contribution**** ____________________%

**** Employer selects contribution amount over 50% or more per employee per month.

5. EMPLOYEE ELIGIBILITY

Total number of employees (including owners):________________________ Number of **ineligible** employees: ________________________

Number of full-time (usually 30 hours per week) employees: ____________ Number of **eligible** employees **declining** coverage: __________

Total number of eligible **enrolling** employees including COBRA/FMLA applicants: ____

Are all eligible employees subject to withholding as on a W-2 form? ☐ Yes ☐ No

Please explain:____

Eligibility date is on the FIRST DAY of the month following the waiting period.

Waiting period for all future employees: ☐ 1 month ☐ 2 months ☐ waive waiting period during group initial enrollment

The following is to be completed by companies of 20 or more total employees and/or employer providing continuation of coverage in accordance with Title X of COBRA: Is your company subject to COBRA? ☐ Yes ☐ No

If yes, please complete the COBRA/FMLA questionnaire.

The following question is to be completed by employers of 50 or more total employees and/or for an employer providing coverage in accordance with the Family and Medical leave Act of 1993: Is your company subject to FMLA legislation? ☐ Yes ☐ No

If yes, please complete the COBRA/FMLA questionnaire.

6. EFFECTIVE DATE - Actual effective date will be assigned by MHHIC underwriting department if policy is issued.

Requested effective date:________________________

Current Carrier - Is this plan intended to replace any existing group coverage?

Health ☐ Yes ☐ No If yes, name of carrier: ____ Proposed termination date: ____________

7. LEAVE OF ABSENCE

A. Number of months employees are eligible to continue health coverage while on an employer-approved temporary **personal** leave of absence:

☐ None ☐ 1 month ☐ 2 months ☐ 3 months ☐ 4 months

B . Number of months employees are eligible to continue health coverage while on an employer-approved temporary **medical** leave of absence **(maximum six months)**:

☐ None ☐ 1 month ☐ 2 months ☐ 3 months ☐ 4 months ☐ 5 months ☐ 6 months

It is the Employer's responsibility to immediately notify MHHIC at the beginning of any authorized leave of absence.

8. MEDICAL INFORMATION

To your knowledge:

1. Is any person to be covered unable to work due to Injury or Illness? ☐ Yes ☐ No
2. Is any person unable to perform the normal duties of another person in the same employment class of the same age and sex? ☐ Yes ☐ No

If yes to either question, provide names, dates, and degree of recovery (use another page if necessary):________________________________

9. WORKERS' COMPENSATION

Name of current Workers' Compensation carrier: ______________________________ Renewal date: ______________

Please list the name and job title of any person to be Included as a subscriber under the MHHIC coverage who IS not an employee, for the purpose of Workers' Compensation law or similar legislation. Please note that under Texas law, partners and corporate officers, or members of boards of directors are employees for Workers' Compensation purposes except under limited circumstances.

Name:	**Title:**	Exempt according to above requirements?
______________________	______________	☐ Yes ☐ No
______________________	______________	☐ Yes ☐ No

10. SIGNATURE/DISCLOSURE STATEMENT

Check the box that applies:

☐ We, the employer, as administrator of an Employee Welfare Benefit Plan under ERISA, apply for the coverage indicated. We understand that any dispute involving an adverse benefit decision may be subject to binding arbitration only after the ERISA appeals procedure has been completed.

☐ We, the employer, as administrator of an Employee Welfare Benefit Plan, which is a church plan or governmental plan as defined under ERISA and therefore not subject to ERISA, apply for the coverage indicated.

☐ We, the employer, agree that MHHIC can provide an electronic copy of the Certificate of Coverage document to us for distribution to our employees, rather than issue a paper copy to each covered employee.

We represent that all information on this Application is true and complete, and that MHHIC may rely on this Application in its decision to evaluate our group for eligibility and rating purposes. If not complete, MHHIC reserves the right to reject the Application and notify us in writing. We understand and agree that coverage will be effective only if we have paid our first month's premium and have met eligibility criteria. We understand that we will be informed of acceptance and effective date in writing if this Application is issued, that we should keep prior coverage in force until so notified and that no agent or broker has the right to accept this Application or bind coverage. This Application and the signature page become a part of our contract with MHHIC. **We verify that these answers are true and that coverage may be re-evaluated for eligibility and rating purposes should it be determined at a future date that there are misstatements in these Application forms. We have provided the individual, or the person through whom the Individual was eligible to be covered as a dependent, prior to declining coverage with an explicit written notice in bold type, specifying that failure to elect coverage during the initial enrollment period permits the plan to impose at the time of the Individual's later decision to elect coverage, an exclusion from coverage until the next open enrollment period and received signed acknowledgement of the notice.**

ARBITRATION AGREEMENT: We understand that any dispute between us and MHHIC may be subject to binding arbitration. The arbitration will be conducted pursuant to the applicable commercial rules of the American Arbitration Association and applicable Texas statutes governing arbitration. The arbitration will be binding only if both parties agree and the arbitration will occur in the county where the policyholder or, if applicable, the beneficiary resides. By signing this Application, we are not agreeing to binding arbitration.

Dated at ______________________________ on the __________ day of ______________ 20________

By X ______________________________ Title ______________________________

(Signature of Company Officer / Owner)

11. CONDITIONAL RECEIPT - Agent, please photocopy and give to your client.

This will acknowledge receipt of $ ______________ from ______________________________ as a deposit against the insurance premiums that would become payable if MHHIC accepts this Application for group coverage. This check will be held in trust by MHHIC pending acceptance or rejection of the Application. I have fully explained to the employer that in no event will benefits be payable for any loss incurred before the effective date assigned by MHHIC and that the company should retain any other coverage until then.

12. AGENT'S CERTIFICATION

☐ I hereby certify that I am not aware of any Information not disclosed in this Application by the employer which may have bearing on this risk.

☐ I hereby certify that I have advised the employer not to terminate any existing coverage until receiving written notification from MHHIC that the coverage being applied for by this Application is issued.

1 NAME OF WRITING AGENT (Print or Type)	% Commission to be Paid	AGENT TAX I.D. NO. (CHECK ONE) ☐ E = EIN ☐ S = SS#
AGENT ADDRESS	PHONE NO. ( )	FAX NO. ( )
CITY / STATE / ZIP		
SIGNATURE OF AGENT X		DATE

2. NAME OF ☐ SUB-AGENT ☐ SECOND WRITING AGENT (Print or Type)	% Commission to be Paid	AGENT TAX I.D. NO. (CHECK ONE) ☐ E = EIN ☐ S = SS#
AGENT ADDRESS	PHONE NO. ( )	FAX NO. ( )
CITY / STATE / ZIP		
SIGNATURE OF AGENT X		DATE
3. NAME OF GENERAL AGENT		AGENT TAX I.D. NUMBER

Send Administration Kit to: ☐ **Agent** ☐ **Group**

Insurance coverage is underwritten by Memorial Hermann Health Insurance Company. The Memorial Hermann Health Insurance Company logo is a registered trademark of Memorial Hermann Health System.

For MHHIC Internal Use Only:
Sales Director
Account Executive

As of the Effective Date indicated above on page one of this Application, MHHIC hereby agrees to issue coverage to the above named Employer, pursuant to the terms and conditions of the attached Group Policy.

____

Company Officer Name, Title

Memorial Hermann Group Data Submission Agreement

The purpose of this Agreement is to direct Memorial Hermann Health Plans (which include Memorial Hermann Health Insurance Company, Memorial Hermann Health Solutions, Inc., and Memorial Hermann Health Plan, Inc. (Health Plans) to accept the Group's enrollment and termination data.

As of the date indicated below, the following terms and conditions apply:

1. You agree to keep paper or electronic copies of actual enrollment forms, and agree to maintain a complete record of enrollment and eligibility information (via electronic and/or hard copy format) including evidence of coverage elections, evidence of eligibility, changes to elections, coverage declines, and terminations. Records must be available to Health Plans and/or regulatory agencies upon request, and retained for seven years.

2. You represent that all enrollment and eligibility information presented to Health Plans is accurate and timely updated. You acknowledge that Health Plans can and will rely on such enrollment and eligibility information in determining whether an individual is eligible for benefits under the plan. In the event of a discrepancy between enrollee information (including salary data) submitted and information actually presented by the enrollee on any particular claim for benefits, and the result is that Health Plans must pay a higher benefit to reflect the actual information presented by the enrollee, you agree to pay promptly to Health Plans applicable back premium equivalents accruing as of the date on which the enrollee's information changed.

3. Insured plans must use Health Plans' supplied forms in paper or electronic format. Self funded plans may use their own forms, but must maintain all statutorily and regulatory required information.

4. You are responsible for adhering to applicable state and federal laws and regulations when submitting enrollment information or terminations to Health Plans.

5. If otherwise permitted, where retro-terminations are submitted, we will regard the submissions as verification that no premium/contribution was paid by the member/dependent for that period.

6. If you use a third party to submit information for you (such as an agent or a broker), you agree that that third party is your agent for legal purposes, and that you are responsible for their actions and/or inactions in submitting information to Health Plans.

7. You agree to submit data in a spreadsheet format, using the fields and formatting indicated by Health Plans. If you use a third party to submit information for you, you agree that they will also have to submit the data in a spreadsheet format and using the fields and formatting indicated by Health Plans.

8. You agree that all provisions in the Group Agreement, Group Policy or Administrative Services Agreement (as appropriate) not specifically modified by this Agreement remain in full force and effect.

The following shall have the same legal force and effect as an original of this document: a photocopy, facsimile, imaged or other electronic version.

I understand and agree to the terms set forth in this Agreement. By signing below, I represent that I am authorized by the Group to sign this Agreement.

Signature	Company Name
Print Name	Employer Identification Number (EIN or FEIN)
Effective Date	Name of Applicable Health Plan

Underwritten by Memorial Hermann Health Life & Health Insurance Company

COBRA AND MEDICARE SURVEY

In order to ensure compliance with state and federal laws, it is necessary to update Memorial Hermann Health Insurance Company annually with your company's COBRA and Medicare status. While eligibility for both is determined per a threshold of 20 employees, your group's status is calculated differently for COBRA and Medicare purposes as detailed below. Failure to supply updated information may result in incorrect payments for your employees' claims and may raise issues for your group under certain applicable federal laws.

Attention Group No.:____

Tax Identification Number (TIN): ______________________________

Group Name: ____

Group Address:____

City State Zip: ____

Please complete this form and mail to the following address:

Memorial Hermann Health Insurance Company
7737 Southwest Freeway, Suite C-97
Houston, Texas 77074

COBRA and Medicare Eligibility
Please provide the requested information for the preceding calendar year. For Medicare status, a worksheet on which to record your group's weekly employee count is included. Include all employees, regardless of their enrollment in a Memorial Hermann Health Insurance Company plan.

COBRA Status	
A. How many full-time employees did your company have for at least 50% of the business days in the preceding calendar year? Include: Seasonal, Owners, Officers Exclude: Self-employed persons, Independent Contractors, Directors	Enter number from Box A here ____________
B. How many part-time employees did your company have for at least 50% of the business days in the preceding calendar year? Include: Seasonal, Owners, Officers Exclude: Self-employed persons, Independent Contractors, Directors Examples: 1. If an employee works 30 hours per week for 10 weeks during the year, DO NOT count as a part-time employee because he or she worked less than 50% of the year. 2. If an employee works 10 hours per week for 30 weeks during the year, DO count as a part-time employee because he or she worked less than 50% of the year.	Enter number from Box B here ____________
C. How many full-time equivalents (FTEs) can be derived from the total number of full and part-time employees listed above? • 1 Full-Time Employee = 1 FTE • 1 Part-Time Employee = a fraction of 1 FTE Example: Company's full workweek is 40 hours per week and it has three full-time employees and three part-time employees. 1 Part-Time Employee works 10 hours per week = 1/4 FTE 1 Part-Time Employee works 20 hours per week = 1/2 FTE 1 Part-Time Employee works 30 hours per week = 3/4 FTE 3 Full-Time Employees work 40 hours per week = 3 FTEs } Company's Total Full-Time Equivalents = 4 1/2 FTEs	Enter the number of FTEs as calculated in Box C here ____________
Based on the information provided above, please indicate your group's COBRA status: ❒ Non-Federal COBRA eligible (Less than 20 Full-Time Equivalents) ❒ Federal COBRA eligible (20 or more Full-Time Equivalents)	

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Medicare Status

A. How many employees did your company have for at least 20 or more calendar weeks during the year?

Include	Exclude
Full-Time	Self-employed persons
Part-Time	Independent Contractors
Seasonal	Directors
Owners	
Officers	

Wk 1 ___	Wk 2 ___	Wk 3 ___	Wk 4 ___	Wk 5 ___	Wk 6 ___
Wk 7 ___	Wk 8 ___	Wk 9 ___	Wk 10 ___	Wk 11___	Wk 12___
Wk 13 ___	Wk 14 ___	Wk 15 ___	Wk 16 ___	Wk 17___	Wk 18___
Wk 19 ___	Wk 20 ___	Wk 21 ___	Wk 22 ___	Wk 23___	Wk 24___
Wk 25 ___	Wk 26 ___	Wk 27 ___	Wk 28 ___	Wk 29___	Wk 30___
Wk 31 ___	Wk 32 ___	Wk 33 ___	Wk 34 ___	Wk 35___	Wk 36___
Wk 37 ___	Wk 38 ___	Wk 39 ___	Wk 40 ___	Wk 41___	Wk 42___
Wk 43 ___	Wk 44 ___	Wk 45 ___	Wk 46 ___	Wk 47___	Wk 48___
Wk 49 ___	Wk 50 ___	Wk 51 ___	Wk 52 ___		

Enter number from Box D here

____

Based on the information provided above, please indicate your group's Medicare status:

❒ Medicare Prime (Less than 20 Full-Time and Part-Time Employees)

❒ Memorial Hermann Health Insurance Company Prime (20 or more Full-Time and Part-Time

Should you have any questions regarding this form, please call your Memorial Hermann Health Insurance Company agent or Memorial Hermann Health Insurance Company Customer Service at 1-888-594-0671.

_______________________________ Group Administrator's Name (please print)

_______________________________ Group Administrator's Signature

_______________________________ Fax Number

_______________________________ Telephone Number

_______________ Date

❒ Please check this box to allow Memorial Hermann Health Insurance Company to use the above data to ensure your group contact information is current.

Tel. 713-338-5252 888.594.0671 www.www.mhhealthplan.org

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MEMORIAL HERMANN
Health Insurance Co

Common Ownership Certification Form

MEMORIAL HERMANN
Health Plan

Why do we need this form completed? It helps us ensure that we are issuing the correct coverage to your group under state and federal law, and cuts down on the paperwork you need to complete. Thanks for your help!

Please complete, sign and submit the Common Ownership Certification.

Renewing Groups- complete and return even if you do not have multiple companies.

Group Name (that should appear on the Group Agreement or Policy)	Employer Identification Number (EIN or FEIN)	Group number (if existing group)

Are there any commonly owned businesses that won't be covered under the group agreement or policy? (Circle either Yes / No) If yes, please explain why: ____

____

____

Business Name (Include the parent company above)	EIN or FEIN	# Eligible Employees	Include this Business?
			YES / NO
			YES / NO
			YES / NO
			YES / NO
			YES / NO
			YES / NO

(The person signing must be an officer or the authorized representative of the parent company above)

I certify that my business applying for coverage with Memorial Hermann Health Insurance Company and/or Memorial Hermann Health Plan, Inc. ("Company") is either: 1) eligible to file a consolidated federal tax return or 2) meets the IRS test for being a controlled group under common control. I further certify there are no other affiliated entities, other than the ones listed above, who are eligible to file a consolidated tax return or are part of the controlled group. I represent that, to the best of my knowledge, the information I have provided is accurate and truthful. I agree to notify Company in the event of a change in any of the information that is the subject of this certification.

I understand that any misrepresentation or fraudulent statement may result in rescission of the group agreement or policy, termination of coverage, an increase in premiums retroactive to the policy date, or other consequences as permitted by law.

Name (please print) and Title	Signature	Date

MEMORIAL HERMANN HEALTH SOLUTIONS, INC.
For itself and its affiliated companies, Memorial Hermann Health Plan, Inc. and Memorial Hermann Health Insurance Company

Automated Clearing House (ACH) Authorization

If you are interested in setting up your account for auto draft payments or make a one-time payment, please complete this form and mail it back to the address below along with a blank check marked "VOID":

Memorial Hermann Health Solutions, Inc.
Attn: Finance
929 Gessner Road, Suite 1500
Houston, TX 77024

You can also fax it to 713-338-6860, or email to member-premiums@memorialhermann.org.

I request and authorize Memorial Hermann Health Solutions, Inc. and/or its designee to obtain payment of amounts becoming due by initiating charges to my account, and I request and authorize the financial institution named below to accept and honor the same to my account. As the account holder, by signing below, I certify, in the event that this draft is being drawn from a company checking account, that I am authorized to approve this transaction. I understand that both the financial institution and Memorial Hermann Health Solutions, Inc. reserve the right to terminate this payment program and/or my participation therein. I also understand that I may discontinue this payment program at any time with advance notice to Memorial Hermann Health Solutions, Inc. by calling 713-338-6678 by the 15th of the month.

Application amounts or initial payments will be deducted as soon as possible.

Please ensure your account is funded to cover the total amount due.

Group Name: ____________________

Group Address: ____________________

Bank Name: ____________________

Name on Account: ____________________

Routing/Transit Number: ____________________

Account Number: ____________________

Payment Options

□ Initial Premium Payment (*approximate first month's premium*): $___________

□ Recurring Monthly Premium Payment*

*(*Drafts occur between the 25th and the end of the month prior to the premium due date)*

□ One Time Premium Payment: $___________ Month:_______________

I have read and accept the above agreement:

Authorized Signature: ____________________

Authorized Printed Name: ____________________

Date: ____________________

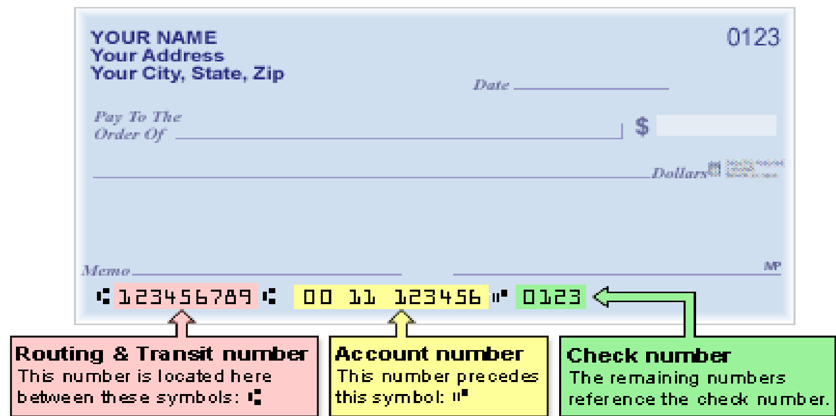
Telephone Number: ____________________

705559 (01/15)

Internal use only

Group No.:________

Check Example:



Internal use only

Group No.:________

MEMORIAL HERMANN®
Health Insurance Co

Medical Coverage underwritten by Memorial Hermann Health Insurance Company

EMPLOYEE ENROLLMENT

Memorial Hermann Health Insurance Company ("MHHIC") GROUP NUMBER
(If existing MHHIC Group)

____

INSTRUCTIONS

1. **You, the employee, should complete this enrollment form in your own handwriting. You are solely responsible for its accuracy and completeness.**
2. **All questions must be answered in full or the enrollment form may be returned to you resulting in a delay in processing.**
3. **Print clearly using black ink. Typed enrollment forms will not be accepted.**

1. COVERAGE

MHHIC METAL PLANS

☐ **Select Platinum 500 PPO**	☐ **Select Gold 1000 PPO**	☐ **Select Silver 3000 PPO**	☐ **Select Bronze 6850 PPO**
	☐ **Select Gold 1500 PPO**	☐ **Select Silver 4500 PPO**	☐ **Select Bronze 5000 HSA PPO**
	☐ **Select Gold 2000 PPO**	☐ **Select Silver 5000 PPO**	☐ **Select Bronze 6550 HSA PPO**
	☐ **Select Gold 2000-3500 PPO**	☐ **Select Silver 4000 HSA PPO**	
	☐ **Select Gold Copay PPO**		

2. EMPLOYEE INFORMATION - *Must be completed by employee.*

☐ New Group Enrollment ☐ Late Enrollment ☐ New Hire ☐ COBRA effective date: |______________|
☐ Family Addition ☐ Re-Enrollment ☐ Change of Coverage ☐ Annual Open Enrollment ☐ State Continuation

LAST NAME	FIRST NAME	MI	MARITAL STATUS ☐Single ☐Married	SOCIAL SECURITY NO.
HOME ADDRESS (P.O. Box not acceptable unless rural P.O. Box)			APT. NO.	HOME PHONE NO.
CITY	STATE	ZIP CODE		EMPLOYEE/SPOUSE'S MAIDEN NAME
GROUP NAME	OCCUPATION / JOB TITLE	FULL-TIME DATE OF HIRE		SPOUSE'S/DOMESTIC PARTNER'S SOCIAL SECURITY NO.
BUSINESS PHONE NO.	E-MAIL			

Please Note: If any dependent has a different address, please write the dependent's name, relationship to the employee, and address on a separate sheet and attach to this enrollment form.

3. EMPLOYEE / DEPENDENT AND DOMESTIC PARTNER INFORMATION - *List yourself and only those eligible dependents who are applying for coverage.*

An eligible "dependent" is an employee's lawful spouse as recognized under Texas Law, or domestic partner; children or step-children who are under age 26; adopted children under age 26, including a child for whom the Eligible Employee is a party in a suit to adopt; or unmarried grandchildren who are under age 26 and are dependents for federal income tax purposes at the time of this enrollment form.

If family addition is spouse, date of marriage: |__________________|

MHHIC may require proof that a domestic partnership exists to ensure eligibility requirements are met.

RELATION	SEX	LAST NAME	FIRST NAME	M.I.	User of Tobacco Products*?	DISABLED?	BIRTH DATE Month Day Year	SOCIAL SECURITY NUMBER
Employee	☐ Male ☐ Female				☐Yes ☐No	☐Yes ☐No		
Spouse /Domestic Partner	☐ Male ☐ Female				☐Yes ☐No	☐Yes ☐No		
	☐ Male ☐ Female				☐Yes ☐No	☐Yes ☐No		
	☐ Male ☐ Female				☐Yes ☐No	☐Yes ☐No		
	☐ Male ☐ Female				☐Yes ☐No	☐Yes ☐No		

**Check Yes if you or the dependent use or have used tobacco an average of four or more times per week within the past six months, excluding religious or ceremonial uses.*

4. COVERAGE DECLINATION - *To be completed if any coverage is declined or refused by an eligible employee and / or their eligible family members.*

A. Medical Group Coverage Declined (please check box or write in requested information)

	Myself	Spouse	Dependent(s)
Covered by spouse/domestic partner's group coverage - List Insurance Company Name:			
List ID Number			
Enrolled in any other Insurance Co. Plan - List Insurance Company Name:			
List ID Number			
Medicare			
Covered by TRICARE			
Other (Explain):			

I acknowledge the available coverage has been explained to me by the Group and know I have the right to enroll in coverage. I have been given the chance to enroll in this coverage and I have decided not to enroll myself and / or my dependent(s), if any. I have made this decision voluntarily and no one has influenced me or pressured me to decline coverage. By declining this group medical coverage (unless employee and / or dependents have group medical coverage elsewhere*), I acknowledge if I wish to enroll at a later date, my dependent(s) and I will have to wait until the Group's next annual open enrollment period.

x ________________________________ ____________________

Signature if declining coverage for employee / dependent(s) ***Date (Month / Day / Year)***

* If you are declining coverage for yourself or your dependents (including your spouse/domestic partner) because of other health Insurance coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards you or your dependents' other coverage). However, you must request enrollment within 31 days of the date you or your dependents' other coverage ends (or within 31 days of the date the employer stops contributing toward the other coverage). In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption (a "qualifying event"), you may be able to enroll yourself and your dependents at that time. However, you must request enrollment within 31 days of the qualifying event.

5. OTHER MEDICAL COVERAGE FOR ALL ENROLLING EMPLOYEES AND DEPENDENTS *(All questions must be answered.)*

	Yes	No
1. Do any persons on this enrollment form intend to continue other Group coverage if this enrollment form is accepted?	☐	☐

If yes, name of person:______________________________

Insurance Co. ________________________ Policy No. ________________

	Yes	No
2. Is any person applying for coverage eligible for Medicare?	☐	☐

If yes, Name: ______________________________

6. AUTHORIZATION/DISCLOSURE STATEMENT *(The following Authorization is to be signed by each employee applying for coverage.)*

I agree: All information on this form is correct and true. I understand that it is the basis on which coverage is issued under the plan. I further authorize the Group to deduct my contribution, if any, from my earnings towards the cost of this plan. I certify that I am working at the Group's place of business in permanent employment for at least 30 hours per week.

I understand that my Group's Application will determine coverage and that there is no coverage unless and until both my Enrollment form and the Group's Applications have been accepted and approved by MHHIC.

I represent that I have read this and that even if this is approved by MHHIC, any misstatements or omissions on this, regarding me or my spouse/domestic partner, as applicable, may result in future claims being denied, or my coverage and/or my spouse's/domestic partner's coverage under the Group's Plan being rescinded or re-evaluated retroactive to my effective date for eligibility and rating purposes.

I am applying for Participating Provider Plan coverage: I understand that I am responsible for a greater portion of my medical costs when I use a nonparticipating provider.

Arbitration Agreement: I understand any dispute between MHHIC and me may be subject to binding arbitration. The arbitration will be conducted pursuant to the applicable commercial rules of the American Arbitration Association and applicable Texas statutes governing such arbitration. The arbitration will be binding only if both parties agree and the arbitration will occur in the county where the Certificate holder or, if applicable, beneficiary resides. By signing this Application, I am not agreeing to binding arbitration. If I am enrolling in an a Group-sponsored plan that is subject to ERISA, I understand that any dispute involving an adverse benefit decision may be submitted to voluntary binding arbitration only after the ERISA appeal process is completed.

☐ This was completed by someone other than me. I, the enrollee, represent I have read all the information provided as responses in this and represent and warrant to MHHIC such information is true, complete and accurate as of the current date, and if I had completed this on my own, the information provided on the enrollment form would remain the same.

☐ I completed this. I, represent to MHHIC I have read all the information provided in response to the questions on this and I represent to MHHIC such information is true, complete and accurate as of the current date.

I, acknowledge I have read and understand this in its entirety.

SIGNATURE OF EMPLOYEE *(Required)*	TODAY'S DATE *(Required)*
X	

SIGNATURE OF EMPLOYEE'S SPOUSE'S/ DOMESTIC PARTNER *(If applying for coverage)*	TODAY'S DATE *(Required)*
X	

Incomplete Enrollment Forms will be mailed back to you for completion. This may delay the effective date of your coverage.

Insurance coverage is underwritten by Memorial Hermann Health Insurance Company. The Memorial Hermann Health Insurance Company logo is a registered trademark of Memorial Hermann Health System.