EMPLOYEE ENROLLMENT - Self-Funded Medical Coverage
2-50 Employees

Employer Name: ____

EMPLOYEE INFORMATION

Email Address: ____

Last Name ____ First Name ______________________________________Initial ______________

Address: ____

Social Security Number: ________ ___ ______ ___ __________

☐Single ☐ Married Gender: ☐Male ☐ Female Date of Birth ___ _______ ____ Height: __________ Weight ____________

Phone Number: ☐ Home ☐ Cell ________ ___ ________ ___ _______________ Date Employed Full-Time: ___ ______ ____

Average Hours Worked Per Week: ____________ Annual Salary: $ ____________ Occupation: ______________ Independent Contractor? ☐ Yes ☐ No

FAMILY INFORMATION (ONLY for those applying for coverage)

First Name, M.I. (last name if different)	Date of Birth	Gender	Height	Weight	Social Security Number	Primary Care Physician's Name
Spouse:		☐ M ☐ F				
Child:		☐ M ☐ F				
Child:		☐ M ☐ F				
Child:		☐ M ☐ F				
Child:		☐ M ☐ F				

COVERAGE INFORMATION

Coverage Type Selected: ☐ Employee Only ☐ Family ☐ Employee & Spouse ☐ Employee & Child (ren)

Name of Selected Medical Plan: ____ PPO Network Name: ____

Change Coverage Request: ☐ Marriage ☐ Divorce ☐ Adoption ☐ Court Order:

Date of Event (you may be required to provide proof of the event): _____ ______ _____

Attach a written and signed statement by the employer for a requested coverage effective date. Effective date may not be guaranteed.

Important Plan Information

Your employer has selected a health plan for you and your family that is self-insured and is provided by a multiple-employer welfare arrangement ("MEWA"). In the event the plan or MEWA does not ultimately pay medical expenses that are eligible for payment under the plan for any reason, your employer or you may be liable for the medical expenses. Please note this Plan does not participate in the Texas Life and Health Insurance Guaranty Association. DISCLOSURE OF GUARANTY FUND NONPARTICIPATION: In the event the MEWA is unable to fulfill its contractual obligation under this contract, the contract holder is not protected by an insurance guaranty fund or other solvency protection arrangement. If you have any complaints and/or issues regarding this plan please contact the Texas Department of Insurance consumer services division at (800) 252-3439 (from 8 am to 5 pm Central time) or send an email to: ConsumerProtection@tdi.texas.gov.

Please note this plan does not participate in the Arkansas Life and Health Insurance Guaranty Association. If you have any complaints and/or issues regarding this plan please contact the Arkansas Department of Insurance consumer services division at (800) 282-9134 (from 8 a.m. to 5 p.m. Central time or send an email to: Insurance.Consumers@Arkansas.gov).

You may obtain a copy of the Summary Plan Description ("SPD") from the Plan Administrator, your employer, a MEWA Trustee or by visiting the website www.membershealthplan.com. Information that is identified in the SPD includes and is not limited to: Plan Description, Purpose, Eligibility Provisions, Managed Care Information, Medical Expense Benefits, Prescription Drug Benefits, General Limitations, Eligibility for Coverage, Late Enrollment, Termination of Coverage, Extension of Benefits, Coordination of Benefits, Third Party Recovery, Subrogation and Reimbursement, Rights under ERISA, General Provisions

ELIGIBILITY / OTHER INSURANCE

Currently, are you working full-time? ☐ Yes ☐ No If no, explain ______________________________

☐ Y ☐ N Do you or any family members intend to keep other insurance coverage in addition to this coverage? If yes, list family members:

____

List the name of the other insurance company(ies) and the policy number(s):______________________________

List family members covered by Medicare and their effective date:______________________________

MEDICAL INFORMATION (REQUIRED)

1. ☐ Y ☐ N Are you or any dependent disabled, hospital confined, or pregnant? If pregnant, due date: _____/_____/_____

   If pregnant, are you expecting a multiple birth / having complications / planning a C-Section? ☐ Y ☐ N

2. ☐ Y ☐ N Are you or any eligible dependent receiving treatment; taking medication; receiving follow up care; scheduled for or awaiting results of any tests, biopsies, procedures or lab work; been advised to have a test; or been advised of a condition that will require attention in the next twenty-four (24) months?

3. ☐ Y ☐ N Have you or any eligible dependent used tobacco products in the past twelve (12) months?

4. ☐ Y ☐ N Have you or any eligible dependent ever been declined, postponed, ridered, or rated up for medical, disability, or life insurance with another insurance carrier? If yes, please explain.

5. In the past five (5) years, have you or any eligible dependent to be insured had any symptoms, diagnosis, consultation, testing, treatment, follow up care, or taken any medication or received counseling for:

   a. ☐ Yes ☐ No Cancer/Tumor
   b. ☐ Yes ☐ No Kidney Disorder Disorder
   c. ☐ Yes ☐ No Stroke
   d. ☐ Yes ☐ No Immune System Disorder
   e. ☐ Yes ☐ No Arthritis/Back/Joint Disorder
   f. ☐ Yes ☐ No Intestinal/Digestive Disorder
   g. ☐ Yes ☐ No Diabetes
   h. ☐ Yes ☐ No Liver Disorder/Hepatitis
   i. ☐ Yes ☐ No Systemic Lupus/Multiple Sclerosis
   j. ☐ Yes ☐ No Mental Disorder Alcohol/Drug Abuse
   k. ☐ Yes ☐ No Heart/Blood/Vascular Disorder/ Hypertension
   l. ☐ Yes ☐ No Birth Defects/Congenital Disorder
   m. ☐ Yes ☐ No Infertility
   n. ☐ Yes ☐ No Respiratory/Lung
   o. ☐ Yes ☐ No Organ/Tissue Transplants
   p. ☐ Yes ☐ No Neurological Disorder
   q. ☐ Yes ☐ No Acquired Immune Deficiency Syndrome (AIDS)/AIDS Related Complex (ARC)/HIV

6. In the past five (5) years, have you or any eligible dependents:

   a. ☐ Yes ☐ No Been diagnosed with or treated for any condition(s) not identified above?
   b. ☐ Yes ☐ No Been advised of the necessity or possibility of any future hospitalization, treatment, testing or surgery?

Please provide details to "Yes" answers, including information regarding last doctor visit and/or physical examination and all medications taken (attach extra pages if needed with signature and date.)

Question/Letter	Name	Illness/Impairment	Treatment Dates	Medication/Treatment/Surgery/Physician

EMPLOYEE WAIVER **(Please complete if you are declining medical coverage)**

Please check all of the following that apply. I waive medical coverage for: ☐ Employee ☐ Spouse ☐ Child (ren)

Please state the reason for waiving coverage: ______________________________ Qualifying Coverage ______________________ Other __________________

If I have waived coverage for myself and/or my dependents (including my spouse) because of other health insurance coverage, I may in the future be able to enroll myself and/or my dependents in the coverage, provided that I request enrollment within 31 days after my other coverage ends because of involuntary loss of other coverage (divorce, death, legal separation, termination of employment, reduction in number of hours of employment). In addition, if I have a new dependent as a result of marriage, birth, adoption, or placement for adoption, I may be able to enroll my dependents, provided that I request enrollment within 31 days after the date of the event. I further understand that if I am considered a late enrollee, I may be declined from coverage or excluded from coverage for a period of time as defined in the Plan Document and where permitted by law, and I may be required to provide, where allowed by law, Medical History satisfactory to the Plan Sponsor or Administrator, for myself and/or my dependents.

EMPLOYEE AGREEMENT – SIGNATURE REQUIRED

*** TO BE A VALID APPLICATION, YOUR SIGNATURE AND THE DATE YOU SIGN IT ARE REQUIRED**

I understand that the previous answers will be relied upon by the Plan Sponsor in the issuance of coverage and a Summary Plan Description. I declare all statements contained in this entire form about me and my dependents are true and correct to the best of my knowledge and that no material information has been withheld or omitted. I understand that my intentional misrepresentation of a material fact or my failure to report information about me or my dependents may be used as the basis to rescind, terminate or modify coverage for me or my dependents. Rescind means that the coverage was never in effect.

I understand that omission of medical conditions may result in the denial of coverage for claims related to the omitted medical conditions. I understand and agree that the Plan Sponsor is not bound by any statement made by or to any agent unless written herein. I agree that no coverage will be effective until the date specified by the Plan Sponsor. The actual effective date may not be the requested effective date. If I am now waiving medical benefits for myself and/or my dependents, I have read the entire Waiver provision, and understand the enrollment requirements if I make a request for such benefits at a later date.

I authorize my employer to deduct the necessary contribution toward the benefits. I reserve the right to revoke this deduction authorization at any time upon my written notice. Benefits are effective only after approval by the Plan Sponsor or Administrator and satisfaction of any probationary period.

Any person who knowingly and with intent to defraud, submits an application or files a claim containing any materially false information may be found guilty of fraud, which is a crime, in a court of law and may be subject to fines and confinement in prison. This will not be considered as a complete application unless all pages are attached and completed.

By providing my e-mail address, I hereby accept electronic delivery of all plan documents to my e-mail address. Plan documents include but are not limited to HIPAA Privacy Notice, Medicare Part D Notices, Summary Annual Report, Summary of Benefits and Coverage, and Summary Plan Description. On occasion, in addition to electronic communications I may also receive a paper document. I understand that I can request a paper copy, free of charge, at any time by calling the Plan. I can withdraw from the electronic delivery process at any time in the future by calling the Plan. I can opt out of the electronic delivery process at this time by checking the box here: ☐

☐ I understand that information on this enrollment form is valid for a maximum of 60 days from the date of signature.

Employee Signature X ____ **Date (required)** __________________________

If signed by a representative of applicant, please indicate the representative's authority to act on behalf of applicant.

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AUTHORIZATION TO RELEASE MEDICAL INFORMATION FOR ENROLLMENT – SIGNATURE REQUIRED

Please clearly print all information.

I hereby authorize any physician, medical practitioner, hospital, clinic, Veterans administrations facility, other medical or medically related facility, insurance or excess loss insurance company, pharmacy, pharmacy benefit manager, or Consumer Reporting Agency, having information available as to the diagnosis, treatment and prognosis with respect to any physical or mental condition, including drug or alcohol use, HIV/AIDS and/or treatment of me or my minor children and other non-medical information of me and my minor children, to release to the claims or third party administrator, any other excess loss insurance carrier designated by the Plan, or its legal representative, any and all such information as required for determination of eligibility for benefits. I also authorize the Plan Sponsor and its duly authorized representatives to disclose member health information when necessary for my care or treatment, payment for services, the operation of the health plan, or to conduct related activities. I have discussed the terms of this authorization with my spouse and competent adult dependents, and I have obtained their consent to the release of their health information. I also understand that my dependents of legal age, in order to be eligible for benefits, may be required to sign a similar release of medical records for the purpose of determining the accuracy of statements made by me on this application and for the ultimate determination of eligibility for benefits under the Plan. I understand that I may request a copy of this authorization at any time. I understand that any information that is disclosed pursuant to this authorization may be re-disclosed and no longer covered by federal rules governing privacy and confidentiality of health information. I declare that I have read this application in full and that all statements contained in this entire form about me and my dependents are true and correct to the best of my knowledge and that no material information has been withheld or omitted. I understand any person who includes any false or misleading information on an application for an insurance policy or health coverage is subject to criminal and civil penalties.

I agree that a photographic copy of this authorization shall be as valid as the original, and that this authorization shall be valid for 2 ½ years from the date signed below or for as long as I, or my dependents, are enrolled in the Plan, whichever is greater. I understand the information obtained by use of this authorization may be used by the Plan Sponsor, claims or third-party administrator, and an y excess loss insurance carrier designated by the Plan to determine eligibility for health coverage, and eligibility for benefits under an existing plan, for myself and my dependents. Any information obtained will not be released to any person or organization, except to reinsuring companies or other persons or organizations performing business or legal services in connection with my enrollment for the coverage, for any claim, for medical management purposes, coordination of care, coordination of benefits, auditing, anti-fraud activities, plan-related analysis and reporting, case management, preventive health, disease management, quality assessment and improvement, managing data and information systems, transitioning policies to other insurers, fulfilling plan's legal and regulatory obligations or as may be otherwise lawfully required or as I may further authorize. I also understand that I have a right to revoke this authorization in writing at any time, except to the extent information has been released in reliance upon this authorization and except to the extent that I, or my dependents, are still covered under the Plan. Should I refuse to sign this authorization, I understand it may affect my enrollment in the benefit plan. All pages must be attached and complete, including this authorization for the application to be considered complete. Incomplete applications may be rejected.

Employee Signature X ____ **Date** ______________________

If signed by a representative of applicant, please indicate the representative's authority to act on behalf of applicant:

Dependent Spouse Signature X ____

Printed Name__________________________**Date** __________

If signed by a representative of applicant, please indicate the representative's authority to act on behalf of applicant:

Dependent Child (18+ Years of age) Signature X ____

Printed Name__________________________ **Date** __________

If signed by a representative of applicant, please indicate the representative's authority to act on behalf of applicant:

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Dependent Child (18+ Years of age) Signature X ____

Printed Name__________________________ **Date** __________

If signed by a representative of applicant, please indicate the representative's authority to act on behalf of applicant:

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MEDICAL INFORMATION (continued)

Please provide details to "Yes" answers, including information regarding last doctor visit and/or physical examination and all medications taken (attach extra pages if needed with signature and date.)

Question/Letter Name Illness/Impairment Treatment Dates Medication/Treatment/Surgery/Physician

FAMILY INFORMATION (continued)

First Name, M.I. (last name if different)	Date of Birth	Gender	Height	Weight	Social Security Number	Primary Care Physician's Name
Child:		☐ M ☐ F				
Child:		☐ M ☐ F				
Child:		☐ M ☐ F				
Child:		☐ M ☐ F				
Child:		☐ M ☐ F				

Employee Signature X ______________________________ **Date (required)** ______________________