***PEDIATRIC ADVANCE LIFE SERVICES HOME HEALTH* CONVERSION PLAN**
PARTICIPATION AGREEMENT

Employee Name: _____ **SSN:** _____

Address: _____

Plan Year: ***12/01/2017*** **through** ***12/31/2018***

As an Eligible Employee in the above Plan, I acknowledge that I have received and read the Summary Plan Description and understand the benefits available to me, as well as the other rights and obligations which I have under the Plan.

I elect to participate in the Plan and agree that my cash compensation will be reduced by the amounts set forth below for the Benefit Option(s) selected.

				Salary Reduction Per Pay Period:	Annual Deduction:
Group Medical Coverage					
☐ *Bronze 6600*	☐ *Silver 2000*				
☐ *Employee*	☐ *Empl & Spouse*	☐ *Empl & Children*	☐ *Family*	$_____	$_____
Dental					
☐ *PPO 20*	☐ *PPO 30*				
☐ *Employee*	☐ *Empl & Spouse*	☐ *Empl & Children*	☐ *Family*	$_____	$_____
Vision					
☐ *Employee*	☐ *Empl & Spouse*	☐ *Empl & Children*	☐ *Family*	$_____	$_____
Life Insurance					
☐ *Employee Only - $25,000 AD&D*				$_____	$_____

CHECK THE BOX BELOW TO DECLINE PARTICIPATION

☐ I elect to waive participation in the Plan and receive my full salary as cash compensation.

OTHER TERMS AND CONDITIONS

I understand that this Participation Agreement is binding for the current Plan Year and may not be modified or revoked unless such modification or revocation is on account of and corresponds with a change in status that affects eligibility for coverage under the Plan, or is otherwise permitted under the Plan.

I further understand that this Participation Agreement will remain in effect for subsequent plan years unless I file a new properly completed and executed Participation Agreement.

I authorize future adjustments in the amount of salary reduction in the event there is a change in the amount of required employee contributions.

This agreement is subject to the terms of the Pediatric Advance Life Services Home Health Premium Conversion Plan, as amended from time to time, shall be governed by and construed in accordance with applicable laws, and revokes any prior Participation Agreement relating to the Plan.

_____ _____
Employee's Signature Date

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

☐ Bronze 6600

☐ Silver 2000

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

(Mandatory)

Group HMO Enrollment Application & Change Form

SECTION 1: REQUESTED ACTION		Please check all that apply – Complete section 5 if declining coverage			
☐	**New Enrollee**	☐	**Termination**	☐	**Change**
☐	Open Enrollment	☐	Terminate **Medical** Coverage (All Members)	☐	Add Dependent(s)
☐	**New Hire/Rehire**	☐	Terminate **Medical** Dependent(s) Coverage	☐	Change Plan Option
☐	Birth/Adoption	☐	Terminate **Dental** Coverage (All Members)	☐	Demographic Change(s)
☐	Late Enrollee	☐	Terminate **Dental** Dependent(s) Coverage		**HIRE DATE:**___________________ **(Mandatory)**
☐	Marriage Date(Proof of Marriage Required)	☐	Terminate **Life** Coverage (Employee Only)		
☐	Loss of Coverage (Proof of Loss Required)		Reason:_______________________________________		
☐	Court Order (Court Order or Decree Required)		_______________________________________		**TERM DATE:**___________________

SECTION 2: EMPLOYEE INFORMATION

First Name	MI	Last Name	Suffix
* Social Security Number	Date of Birth (MM/DD/YYYY)	☐ Male ☐ Female	Employment Status: ☐ Exempt ☐ Non Exempt ☐ Retired
Marital Status ☐ Single/Divorced/Widow ☐ Married ☐ Other___________________		Primary Language: ☐ English ☐ Spanish ☐ Other (Please Specify):_________________________	

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
Do you have a disability affecting your ability to communicate or read? ☐ Yes ☐ No	
Will you enroll in Dental Coverage? ☐ Yes ☐ No	Will you enroll in Life Insurance Coverage? ☐ Yes ☐ No

SECTION 3: DEPENDENT INFORMATION

DEPENDENT	First Name	MI	Last Name	Suffix
	* Social Security Number	Date of Birth (MM/DD/YYYY)	☐ Spouse ☐ Child ☐ Grand Child	☐ Male ☐ Female
	Disability affecting your ability to communicate or read? ☐ Yes ☐ No		Primary Language: ☐ English ☐ Spanish ☐ Other	
	Will you enroll in Dental Coverage? ☐ Yes ☐ No		Will you enroll in Life Insurance Coverage? ☐ Yes ☐ No	
DEPENDENT	First Name	MI	Last Name	Suffix
	* Social Security Number	Date of Birth (MM/DD/YYYY)	Relationship ☐ Child ☐ Grand Child	☐ Male ☐ Female
	Disability affecting your ability to communicate or read? ☐ Yes ☐ No		Primary Language: ☐ English ☐ Spanish ☐ Other	
	Will you enroll in Dental Coverage? ☐ Yes ☐ No		Will you enroll in Life Insurance Coverage? ☐ Yes ☐ No	
DEPENDENT	First Name	MI	Last Name	Suffix
	* Social Security Number	Date of Birth (MM/DD/YYYY)	Relationship ☐ Child ☐ Grand Child	☐ Male ☐ Female
	Disability affecting your ability to communicate or read? ☐ Yes ☐ No		Primary Language: ☐ English ☐ Spanish ☐ Other	
	Will you enroll in Dental Coverage? ☐ Yes ☐ No		Will you enroll in Life Insurance Coverage? ☐ Yes ☐ No	
DEPENDENT	First Name	MI	Last Name	Suffix
	* Social Security Number	Date of Birth (MM/DD/YYYY)	Relationship ☐ Child ☐ Grand Child	☐ Male ☐ Female
	Disability affecting your ability to communicate or read? ☐ Yes ☐ No		Primary Language: ☐ English ☐ Spanish ☐ Other	
	Will you enroll in Dental Coverage? ☐ Yes ☐ No		Will you enroll in Life Insurance Coverage? ☐ Yes ☐ No	

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

(Mandatory)

SECTION 4: 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 5: DECLINATION OF COVERAGE

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 of 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 placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

☐ 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:

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

SECTION 6: DISCLOSURES

[**Consumer Choice Benefit Plans**: 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 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.]

As applicable, enrollee may select an obstetrician or gynecologist as set forth in the Texas Insurance Code Chapter 1451, Subchapter F. Enrollee may designate the selection here: _____

Enrollee is not required to select an obstetrician or gynecologist, but may instead receive obstetrical or gynecological services from her primary care physician or primary care provider.

SECTION 7: 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 Scott and White Health Plan 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.

Signature:	Print Name:	Date (MM/DD/YYYY)

Send completed application by one of the following methods:	**Email:**	Email: swhpgroupenrollment@sw.org ***Subject line: Group Name/Group Number/Division***
	Fax:	Fax 254-298-3199
	Mail:	Scott and White Health Plan MS-A4-126 1206 West Campus Drive Temple, TX 76502
	Portal:	If applicable If experiencing issues with application on portal, please email swhpgroupenrollment@sw.org with Request ID#.

Enrollment/Change Form

Group Dental Insurance, Vision Care Insurance, Basic Life and Basic AD&D Insurance, Supplemental Life and Supplemental AD&D Insurance, Short Term Disability Insurance, Long Term Disability Insurance provided by:

UNITEDHEALTHCARE INSURANCE COMPANY
185 Asylum St.
Hartford, CT 06103-3408

UnitedHealthcare®

TO BE COMPLETED BY EMPLOYER

Employer Name:		Policy Number:
Employer Authorization:	Date of Hire: ___/___/___	Class:
	Plan Variation/Reporting Code:	Plan:
Requested Effective Date of Coverage / Date of Change: ___/___/___		☐ Enroll ☐ Cancel ☐ Change

Reason: (Check the Appropriate Boxes)

☐ New Group Plan ☐ New Hire ☐ Annual Open Enrollment ☐ Address Change
☐ Name Change ☐ Employee Terminated ☐ Marriage ☐ Birth
☐ Divorce ☐ Court Ordered Dependent ☐ Death
☐ Adoption/Legal Custody ☐ Cobra/State Continuation
☐ Other: Start Date ___/___/___ End Date ___/___/___

Employee Type (Check all that apply): ☐ Active ☐ Hourly ☐ Salary ☐ Union ☐ Non-union ☐ Retired ☐ Other

Annual Salary $_____ | Number of hours worked per week: _____

EMPLOYEE INFORMATION

SS# ___ ___ ___ - ___ ___ - ___ ___ ___ ___	Employer Assigned ID#		Date of Birth: ___/___/___
Last Name:	First Name:		Middle Initial:
Address:	City:	State:	Zip Code:
Home Phone:	Work Phone:		Email Address:
Sex: ☐ Male ☐ Female	Marital Status: ☐ Single ☐ Married ☐ Domestic Partner *		

PRODUCT SELECTION

Person	Dental PPO 20	Dental PPO 30	Vision	Basic Life w/AD&D	Supp Life	Supp AD&D	STD	LTD
Employee	☐	☐	☐	☐ $25,000	☐ $_____	☐$_____	☐Core	☐Core
Spouse (or Dom Part*)	☐	☐	☐		☐ $_____	☐$_____	☐Buy-up	☐Buy-up
Dependent Child(ren)	☐	☐	☐		☐ $_____	☐$_____		
	☐ Waive (if applicable) Plan Code: _____	☐ Waive (if applicable)	☐ Waive (if applicable)	☐ Waive (if applicable)	■ Waive Have you used tobacco of any kind in the past 12 months? ☐Yes ☐No Spouse? ☐Yes ☐No	■ Waive	■ Waive (if applicable)	■ Waive (if applicable)

Life Insurance Beneficiary(ies) Full Name and Address	Relationship
1)	_____ ☐ Primary ☐ Secondary
2)	_____ ☐ Primary ☐ Secondary

FAMILY INFORMATION	Dependents to be enrolled, cancelled, changed: (Attach additional sheet if necessary)				
Check Appropriate Box	First Name MI Last Name (if different) Dependent Social Security Number or Assigned ID	Date of Birth	Sex	Relationship**	Incapacitated***
☐ Enroll ☐ Change ☐ Cancel	 SS# ___ ___ ___ - ___ ___ - ___ ___ ___ ___	__/__/__	☐ M ☐ F	☐ Spouse ☐ Domestic Partner*	Not Applicable
☐ Enroll ☐ Change ☐ Cancel	 SS# ___ ___ ___ - ___ ___ - ___ ___ ___ ___	__/__/__	☐ M ☐ F	Dependent	☐Yes ☐No
☐ Enroll ☐ Change ☐ Cancel	 SS# ___ ___ ___ - ___ ___ - ___ ___ ___ ___	__/__/__	☐ M ☐ F	Dependent	☐Yes ☐No
☐ Enroll ☐ Change ☐ Cancel	 SS# ___ ___ ___ - ___ ___ - ___ ___ ___ ___	__/__/__	☐ M ☐ F	Dependent	☐Yes ☐No
☐ Enroll ☐ Change ☐ Cancel	 SS# ___ ___ ___ - ___ ___ - ___ ___ ___ ___	__/__/__	☐ M ☐ F	Dependent	☐Yes ☐No

*Domestic Partner coverage is determined by state law or as determined by your employer. Please contact your employer for confirmation.

**For court ordered Dependent(s), legal documentation must be attached. Please see an Employer representative for more information about the qualifications for full-time student status. If Dependent(s) does not reside with enrollee, please provide address on separate sheet.

*** Dependent is unmarried, incapable of self-sustaining employment because of mental retardation or physical disability; and chiefly dependent on the subscriber/covered person for support and maintenance. If answered "Yes" for Incapacitated, please attach medical certification of disability.

AUTHORIZATION AND ACKNOWLEDGEMENT
(form must be signed)

I hereby declare that all the statements made above are, to the best of my knowledge and belief, true and complete and that they are the basis on which insurance requested by me may be issued.

If Dental and/or Vision product has been elected, I understand that the Dental and/or Vision benefit plan I have selected provides reimbursement for certain Dental and/or Vision costs which are more fully described in the current Certificates of Coverage. I understand there may be instances where treatment decisions made by my Dentist, provider or me for Dental and/or Vision expenses which I have incurred may not be covered by my Dental and/or Vision benefit plan. The Certificates provide Dental and/or Vision benefits only. Review your Certificates carefully.

All statements made by me are: representations; and, not warranties. No statement made by me will be used to: contest the insurance provided by the Policy, unless, it is contained in a written statement signed by me; and, a copy of the statement is furnished to me or my beneficiary.

I understand that by signing this form I am authorizing the necessary premium deductions from my salary or wages for the coverage(s) I have selected. I acknowledge that I have read the applicable Fraud Warning Notices provided below.

FRAUD WARNING NOTICES: (Please review the notice that applies in your state.)

For residents of Colorado:
It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds, shall be reported to the Colorado division of insurance within the Department of Regulatory Agencies.

For residents of District of Columbia:
WARNING: It is a crime to provide false or misleading information to an insurer for purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the application.

For residents of Hawaii:
For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

For residents of Kansas:
Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information may be guilty of fraud as determined by a court of law.

For residents of Kentucky:
Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto may commit a fraudulent insurance act, which is a crime.

For residents of Maryland:
Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

For residents of New Jersey:
Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

For residents of New Mexico:
ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.

For residents of Ohio:
Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

For residents of Oklahoma:
Warning: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

For residents of Oregon:
Any person who makes an intentional misstatement that is material to the risk may be found guilty of insurance fraud by a court of law.

For residents of the state of Pennsylvania:
Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

For residents of Vermont:
Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information may be guilty of a crime.

For residents of Virginia:
Warning: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information may have violated state law.

For residents of Washington:
It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

For residents of all other states:
Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

For residents of Florida:
Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Employee/Enrollee Signature:	Date: