



**2020  
LARGE GROUP MEDICAL  
Enrollment/Change Form**  
HMO • 800.884.4901  
PPO • 800.240.3270  
FirstCare.com

**PLEASE  
CHECK  
ONE IN  
EACH  
SECTION**

- HMO – Select Plus Network
- PPO – Access Network
- Active Employee     Retiree     COBRA
- Texas State Continuation of Coverage

**PLEASE PRINT CLEARLY.**

**ALL REQUIRED DOCUMENTATION MUST BE ATTACHED.**

If you have chosen a Consumer Choice Plan, please read the following disclosure: You have the option to choose this Consumer Choice of Benefits Health Insurance Plan/Health Maintenance Organization health care plan that, either in whole or part, does not provide state-mandated health benefits normally required in evidences of coverage or Health Insurance Plan 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 that 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 policy/evidence of coverage.

**A. Employment Information**

Employer Group Name	Group/Division #	Hire Date	Effective Date
If multiple plans are offered, please write the name of your plan choice here:			

**B. Employee Information**

<input type="checkbox"/> New Applicant		<input type="checkbox"/> A Current Member wishing to make a change? <i>Indicate your Member # and reason for change.</i> Member # _____ or Employee SSN: _____	
<b>Reason for Change (CHECK ONE):</b>			
<input type="checkbox"/> Change Address	<input type="checkbox"/> Add Dependent(s)	Qualifying Event: _____	
<input type="checkbox"/> Select or Change Physician	<input type="checkbox"/> Enroll in COBRA	Qualifying Event: _____	
<input type="checkbox"/> Enroll in Texas State Continuation of Coverage	Qualifying Event: _____		
<input type="checkbox"/> CANCEL ALL COVERAGE – CHECK REASON: <input type="checkbox"/> Termed Employment <input type="checkbox"/> Loss of Eligibility <input type="checkbox"/> Death of Member <input type="checkbox"/> Other (Explain) _____			
<input type="checkbox"/> DELETE DEPENDENT(S) AS LISTED BELOW – Last Date of Coverage: _____ Reason for Termination: _____			
First Name	MI	Last Name	Suffix
Address		Apt#	Date of Birth
City		State	Zip
Primary Language		Married?	PCP (HMO Plans Only)
Special Communication Requirements?		<input type="checkbox"/> Yes <input type="checkbox"/> No (If Yes, explain)	OB/GYN (Complete only if Plan requires selection of Physician)
			Current Patient?
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			Current Patient?
			<input type="checkbox"/> Yes <input type="checkbox"/> No

**C. Family Information (Complete this section if enrolling your spouse and/or dependents. Use additional forms if necessary.)**

Indicate Relationship: **SP** - Spouse; **DE** - Dependent Child; **HA** Handicapped Dependent; **GR** - Grandchild; **OD** - Custody/Guardianship/Adoption (party to a suit); **CO** - Court Ordered Dependent (**\*Documentation Required within 31 days**) Print name as it should appear on ID Card.

Full name of Dependent	Social Security #	Relation Code	Sex	Birth Date	PCP #	OB/GYN #
					<input checked="" type="checkbox"/> if current patient	<input checked="" type="checkbox"/> if current patient

**D. Other Health Insurance Information (Required for Coordination of Benefits. Incomplete information may result in nonpayment of claims)**

The day your coverage begins, will any family members be covered by other Health Insurance or Medicare?  No  Yes (If Yes, complete this section)

Insurance Company Name and Phone Number	Name of Insured	
Names of Family Members Covered	Policy Number	Policy Coverage Date
	_____ to _____	
If MEDICARE: <b>Part A</b> <input type="checkbox"/> No <input type="checkbox"/> Yes <b>Part B</b> <input type="checkbox"/> No <input type="checkbox"/> Yes		
Do you currently have a workers' compensation claim? <input type="checkbox"/> No <input type="checkbox"/> Yes    Have you had a workers' compensation claim within the last 12 months? <input type="checkbox"/> No <input type="checkbox"/> Yes		

FirstCare is a service mark of SHA, L.L.C.  
FirstCare PPO is the product name of Southwest Life & Health Insurance Company.  
Southwest Life & Health Insurance Company is a wholly owned subsidiary of SHA, L.L.C.

**E. Waiver—Refusal of Coverage** *(Required if you are declining any of the coverage available through your employer.)*

I hereby decline group coverage for:  Myself  My Spouse  Dependent Children

If you are declining health enrollment for yourself or your dependents (including your spouse) because of other medical coverage, you may in the future be able to enroll yourself or your dependents in the health plan, provided that you request enrollment within 31 days or as mandated by state law after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, court-ordered medical child support, 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, placement for adoption, or when the enrollee becomes a party in a suit in which adoption is sought.

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Instructions**

- Please print clearly, using blue or black ink.
- Be sure to complete each area where information is requested or access to health care services may be delayed.
- In the upper right of the form, indicate plan selection and member status.
- Provide the name of your employer, hire date and effective date of coverage in Section A.
- When making a change, Employee MEMBER NUMBER, or Social Security Number, and name must be included when submitting the form for changes. The reason for the change must also be checked. Please provide qualifying event where appropriate.
- Complete all Employee Information fields requested in Section B.
- Selection of a Primary Care Physician (PCP) is requested unless your plan is a FirstCare PPO offered by SWL&H. List your physician choice by the Physician's Number provided in the plan provider directory available through your employer or on our web site ([www.FirstCare.com](http://www.FirstCare.com)). Female enrollees may also indicate a choice of OB/GYN.
- Complete Section C if enrolling your spouse and/or dependents. If you have more dependents to enroll than space allows, you may attach a second enrollment form. Be sure that the employee name and member number or social security number is on the second form and stapled to the initial form.
- If you are enrolling a dependent with a relationship code that requires proof of eligibility documentation, please attach the documentation to this enrollment form to expedite processing. Contact your HR Department or Benefits Coordinator for information concerning what documentation is necessary. Please be sure to indicate other coverage for dependents and dependent's address if different from the employee.
- It is very important that you carefully read the section on authorization below, sign and date Section F for acceptance of coverage. If waiving coverage for any or all eligible family members, Section E must be completed.
- If you need any assistance with completing this form, please contact our Customer Service Department at the number listed at the top of the form.
- **Please return the completed form to your HR Department or Benefits Coordinator.**

**ATTENTION HR DEPARTMENT/BENEFITS COORDINATOR:** Fax this completed form to FirstCare Health Plans, ATTN: Enrollment, at 512.257.6031 or 512.257.6027.

## Authorization (Read carefully before signing Section F)

- I understand that the execution and delivery of this Enrollment Form to FirstCare, Southwest Life & Health Insurance Company or FirstCare Administrative Services and/or any acceptance of services by me or any of my eligible dependents shall constitute acceptance and agreement to the terms, conditions and provisions of the benefit plan applicable to me and my dependents.
- I hereby acknowledge I have read the statements in this application, or they have been read to me, and the statements are true and complete to the best of my knowledge and belief and, together with any supplements thereto, shall be the basis for any Evidence of Coverage, Certificate of Insurance or the employer's Plan Document issued. I understand any intentional misrepresentation of a material fact contained herein may be used to reduce or deny claims or void the contract within the contestable period if such misrepresentation of a material fact affects acceptance of the risk. I understand and agree that neither the employer nor the agent has the authority to waive a complete answer to any question, pass on coverage or insurability, alter any contract, or waive any of the company's other rights or requirements. I hereby enroll for benefits for which I am presently eligible, or for which I may become eligible, under my employer's group contract(s).
- I authorize deductions for this coverage from my earnings if any such deductions for this coverage are required. I reserve the right to revoke this deduction authorization at any time upon written notice.
- Any person who knowingly and with intent, to injure, defraud or deceive any insurer, files a claim or an application containing any false, incomplete or misleading information may be guilty of a crime. I hereby agree that no coverage will be effective until the date specified by the company on the Member's or Insured's ID card after this application has been accepted.
- I specifically agree that FirstCare, Southwest Life & Health Insurance Company or the self-funded employer may be fully subrogated, to the fullest extent permitted by law, to any rights which I or any of my eligible dependents may have against third parties (whether in tort, by contract, by statute or otherwise) for any and all payments made by FirstCare, Southwest Life & Health Insurance Company or through FirstCare Administrative Services on my behalf. Further, I specifically agree to execute any reasonable documents deemed necessary by FirstCare, Southwest Life & Health Insurance Company or FirstCare Administrative Services to evidence and perfect such subrogation rights.
- I authorize any physician, medical practitioner, hospital, clinic, other medical or medically-related facility, the Medical Information Bureau, Inc. (MIB Inc.), consumer reporting agency, insurance or reinsuring company, or employer having certain information about me or my dependents to give FirstCare, Southwest Life & Health Insurance Company or FirstCare Administrative Services or its legal representative, any such information. The nature of the information authorized to be disclosed includes information about (1) physical condition(s); (2) health history(ies), prescription drug history(ies), medical records and/or x-ray films; (3) avocation(s); (4) age(s); (5) occupation(s); and (6) personal characteristics.
- I understand that all HMO care covered by FirstCare or FirstCare Administrative Services, must be provided, arranged, or approved by my designated primary care physician or designated OB/GYN physician, in order to be covered by the FirstCare Evidence of Coverage or self-funded employer's Plan Document. I understand the information obtained by use of the authorization may be used by FirstCare, Southwest Life & Health Insurance Company, or FirstCare Administrative Services, to determine eligibility for coverage and eligibility for benefits under an existing policy and plan administration, including quality assurance, medical management, case management, coordination of benefits and health promotion/disease management.

Furthermore, I understand that the information obtained by use of the authorization may be used to identify existing policies for purposes of subrogation.

FirstCare, Southwest Life & Health Insurance Company or FirstCare Administrative Services will not release any information obtained to any person or organization except for treatment, payment or healthcare operations as defined by the Health Insurance Portability and Accountability Act of 1996, as amended in connection with my application, claim or as may be otherwise lawfully required, or as I may further authorize. I know that I may request to receive a copy of this authorization. I agree that a photographic copy of this authorization shall be as valid as the original. I agree that this authorization shall be valid for the duration of my coverage under this group plan.

## F. Authorization and Signature

I hereby represent and certify that all information provided herein is true and complete to the best of my knowledge.

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_