FirstCare HEALTH PLANS

MEDICAL
Enrollment/Change Form

FirstCare HMO • (800) 884-4901
FirstCare PPO • (800) 240-3270
www.firstcare com
Instructions on Back

PLEASE CHECK ONE IN EACH SECTION
❑ FirstCare HMO ❑ FirstCare PPO ❑ FirstCare POS
❑ Active Employee ❑ Retiree ❑ COBRA ❑ Texas 6 Month Continuation

PLEASE PRINT CLEARLY ALL REQUIRED DOCUMENTATION MUST BE ATTACHED

You have the option to choose this Consumer Choice of Benefits Health Maintenance Organization/Health Insurance Plan that, either in whole or part, does not provide state-mandated health benefits normally required in accident and sickness insurance policies/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 that those normally included as state-mandated health benefits in policies 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

❑ New Applicant ❑ A Current Member wishing to make a change? Indicate your Member # and the reason for change, Member #________________________or Employee SSN:________________________

Reason for Change (CHECK ONE):
❑ Change Address
❑ Select or Change Physician
❑ Enroll in Non-Group Conversion
❑ Add Dependent(s) Qualifying Event________________________
❑ Enroll in COBRA: Qualifying Event________________________
❑ Enroll in Texas 6 Month Continuation: Qualifying Event______________

❑ CANCEL ALL COVERAGE - CHECK REASON: ❑ Termed Employment ❑ Loss of Eligibility ❑ Death of Member ❑ Other (Explain)____________________
❑ DELETE DEPENDENT(S) AS LISTED BELOW - Last Date of Coverage:____________________

First Name MI Last Name Suffix	Social Security Number (required)	Home Phone ( )
Address Apt#	Date of Birth ❑ Male ❑ Female	WorkPhone ( )
City State Zip Code	E-mail Address	
Primary Language Married? ❑ Yes ❑ No	PCP (HMO Plans Only) Current Patient? ❑ Yes ❑ No	
Special Communication Requirements? ❑ Yes ❑ No (If Yes, Explain)	OB/GYN (Complete only if Plan requires selection of Physician) Current Patient? ❑ Yes ❑ 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 # ☒ if current patient	OB/GYN # ☒ if current patient
					❑	❑
					❑	❑
					❑	❑
					❑	❑
					❑	❑

D. Previous Coverage Information (Complete for PPO or Self-Funded Coverage)

A written certificate or other verifiable proof of prior coverage for the previous 12 months of coverage must be provided for each enrollee in order to receive credit for pre-existing waiting periods. Please check appropriate box: ❑ No prior coverage. ❑ Certificate of prior coverage is attached. ❑ Written certificate or other verifiable proof of prior coverage will be provided once received from prior plan. Please note: Failure to return Written certificate or other verifiable proof of prior coverage will result in delay in processing and/or denial of payment of health care claims.

E. 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: **Part A** ❑ No ❑ Yes **Part B** ❑ No ❑ Yes	

Do you currently have a workers' compensation claim? ❑ No ❑ Yes; Have you had a workers' compensations claim within the last 12 months? ❑ No ❑ Yes

F. Waiver - Refusal of Coverage (You must complete this section 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 heath 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:________________

G. Authorization and Signature (Please carefully read back of form before signing)

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

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 required unless your plan is a FirstCare PPO plan 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). A PCP will be issued if not indicated on this form. 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 G for acceptance of coverage. If waiving coverage for any or all eligible family members, Section F 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: Forward this form to FirstCare Healthplans, 12940 N. Highway 183, Austin, TX 78750 or fax to (512) 257-6031 or (512) 257-6027.

Authorization (Read carefully before signing Section G)

- 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 anytime 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 ~~shall~~ 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.