ph: 210-267-2349

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HEALTH & DISABILITY BENEFIT INFORMATION FORM **May be Photocopied or Duplicated for use.**

Please complete in ink and initial any alterations.

SECTION 1 – MEMBER INFORMATION

FULL NAME OF EMPLOYEE			SOCIAL SECURITY NUMBER	MARITAL STATUS	**ADM. USE ONLY**
RESIDENCE ADDRESS		EMAIL			CASE NO.
CITY	STATE	ZIP	TELEPHONE NUMBER (include area code)	BEST TIME TO CALL	EMPLOYEE NO.
GENDER / DATE OF BIRTH		HEIGHT	WEIGHT	TOBACCO USE ☐ YES ☐ NO	CLASS
AVG. NO. HOURS WORKED WEEKLY	YEARLY INCOME - W2, 1099			DATE BEGAN FULL TIME (mm/dd/yy)	EFFECTIVE DATE
EMPLOYED BY	CITY	STATE	ZIP		OCC ☐ YES ☐ NO
☐ I AM ☐ I AM NOT AN OWNER, PARTNER OR CORPORATE OFFICER					MHX EMPLOYEE & DEPENDENTS ☐ YES ☐ NO

I am enrolling for (check all that apply):____MEDICAL_____DENTAL____VISION ___LIFE_____DISABILITY

I Am Enrolling for (check one): ☐ SELF ONLY ☐ SELF AND SPOUSE ☐ SELF AND CHILD(REN) ☐ SELF, SPOUSE & CHILD(REN)

DEPENDENT WAIVER

If you have dependents (spouse and/or children) and are not enrolling **all** of them, please complete the following:

I AM NOT ENROLLING MY (check one or both): ☐ **SPOUSE** ☐ **CHILD(REN)**

BECAUSE (check one): ☐ Covered by another group/individual health plan ☐ Other (explain) _____

I understand I have the right to enroll my dependents at this time. I am voluntarily declining to enroll my dependents and have not been encouraged or pressured by anyone to decline such coverage. I understand that if I do not enroll my dependents at this time, and they do not have other qualifying coverage, their right to enroll in the future may be restricted, with a delayed effective date.

DEPENDENT INFORMATION **Complete for each dependent to be enrolled. (use additional sheet if necessary).**

NAMES OF DEPENDENTS	M/F	RELATIONSHIP	SOCIAL SECURITY NUMBER	DATE OF BIRTH	HEIGHT	WEIGHT	TOBACCO USE	EMAIL & PHONE NUMBER (for spouse and dependents 18 & older)
	☐ M ☐ F						☐ YES ☐ NO	
	☐ M ☐ F						☐ YES ☐ NO	
	☐ M ☐ F						☐ YES ☐ NO	
	☐ M ☐ F						☐ YES ☐ NO	

MEDICARE ID: _____

PART A EFFECTIVE DATE:___/___/___PART B EFFECTIVE DATE:___/___/ ____

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Federal Health Insurance Marketplace Premium Assistance Information

1.Number of members of household: _____

2. Federal tax filing status: _____

3. Household Income: _____

4. Are you eligible for enrollment in a group health insurance plan?_____

5. Are you eligible for Medicaid? _____

6. Are your dependents eligible for Medicaid (CHIP)?_____

7. Have you been denied eligiblity for Medicaid and or CHIP benefits?_____

8. Are you eligible for Medicare? _____

9. Are you eligible for COBRA? _____

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SECTION 2 – MEDICAL INFORMATION

This information is required. Any material misrepresentation or omission may result in termination of your coverage and may constitute fraud. Please answer completely.

Please check "YES" or "NO" for each item and provide details for all "YES" answers in the space provided.

1. In the past 5 years, have you or anyone enrolling for coverage had a diagnosis of or consultation, treatment or medication for:

	YES	NO		YES	NO
Brain or Nervous System	☐	☐	Diabetes or Sugar in Urine	☐	☐
Endocrine or Adrenal Disorder	☐	☐	Digestive/Gastrointestinal Disorder	☐	☐
Liver, Pancreas or Kidney	☐	☐	Breast or Reproductive Organs	☐	☐
Abnormal Blood Pressure	☐	☐	Autoimmune Disorders	☐	☐
Heart or Circulatory System	☐	☐	Disorders of Back or Spine	☐	☐
Chest Pain or Stroke	☐	☐	Rheumatoid Arthritis	☐	☐
Cancer (excluding Basal Cell or Carcinoma)	☐	☐	Emphysema, Tuberculosis or Chronic	☐	☐
Disease of the Muscles	☐	☐	Obstructive Pulmonary Disease	☐	☐
Cirrhosis or Hepatitis	☐	☐	Multiple Sclerosis or Cystic Fibrosis	☐	☐
Leukemia or Hodgkin's Disease	☐	☐	HIV or AIDS	☐	☐
Hemophilia	☐	☐	Congenital Birth Defects	☐	☐

2. Is anyone enrolling for coverage disabled, in any way unable to perform the normal activities of daily living or self care or anticipating surgery or other medical treatment? ☐ YES ☐ NO

3. Are you or any dependent (whether enrolling for coverage or not) currently pregnant, experiencing any complications, or currently receiving infertility testing or treatment? ☐ YES ☐ NO

4. During the past 5 years, has anyone enrolling for coverage visited a doctor, had a medical consultation, had surgery, or been hospitalized for any condition not already indicated above? ☐ YES ☐ NO

Use this space to provide details to any "YES" answer to questions 1 through 4. If you have high blood pressure, please include your last 3 blood pressure readings.

Medical Conditions – Complete for each person's medical conditions (if you need additional space go to last page).

Person	List Medical Conditions and/or specific treatments. Include any anticipated treatment or surgery.	Dates of Treatment	Medications & Dosages	Recovery Status

5. Is anyone enrolling for coverage currently taking medication? (If yes, enter details directly below) ☐ YES ☐ NO

Medical Information – Complete for each person's medication information (if you need additional space go to last page).

Person	Medication Name	Generic RX? Yes or No	Dosage & Frequency of Use	Reason for Prescription

Have you or any applicant been convicted of ANY felony or DWI in the past 5 years? ____ Yes ____ No

SECTION 3 – MEMBER STATEMENT AND SIGNATURE

PERSONAL INFORMATION NOTICE: As required by law, this notice is intended to inform you that 1) Personal information may be collected from third parties; 2) Such information as well as other personal or privileged information collected by the health plan or its legal representative may be in certain instances, as prescribed by law, disclosed to other third parties without your prior authorization; 3) You have the right to access and correct the collected information; 4) Your right to access does not include any information which relates to and is collected in connection with, or in reasonable anticipation of, a claim or civil or criminal proceeding; 5) We will provide a more detailed notice of information practices upon request.

AUTHORIZATION FOR RELEASE OF INFORMATION: I authorize the disclosure of all nonpublic personal information and individually identifiable protected health information for me (and my dependent(s), if applicable), including but not limited to employment status, other health plan coverage, diagnosis, prognosis, medical treatment or care, and physical or mental conditions (including alcohol or drug dependency), by any physician, medical practitioner, hospital, other medical related facility, insurance company, employer or benefit plan having such information, to the health plan or its legal representative, agent or vendor, for the purpose of processing enrollment and claims. I acknowledge and agree that this authorization shall be valid for two (2) years; that I may revoke it in writing at any time; that I may request a copy of this authorization; that enrollment, but not the processing of claims, is conditioned on my signing this authorization; that this authorization will be used as its own document, separate from the enrollment form; that a photocopy of this authorization shall be as valid as the original; that any documentation or information disclosed pursuant to this authorization may be re-disclosed and may no longer be covered by federal or state privacy laws; and that I have authority to act as the personal representative of my dependent(s) (if requesting dependent coverage).

Member Name_____Date _____
(Type Name as signature authorization)

Spouse_____Date_____
(Type Name as signature authorization)

PRESCRIPTION MEDICINES (PLEASE PROVIDE CURRENT MEDICINES PRESCRIBED)

Name:_____, Dosage/ Day:_____, Member:_____

Name:_____, Dosage/Day:_____, Member: _____

Name:_____, Dosage/Day:_____, Member: _____

Name:_____, Dosage/Day:_____, Member: _____

Name:_____, Dosage/Day:_____, Member: _____

Name:_____, Dosage/Day:_____, Member: _____

Name:_____, Dosage/Day:_____, Member: _____

Name:_____, Dosage/Day:_____, Member: _____

Name:_____, Dosage/Day:_____, Member:_____

Name:_____, Dosage/Day:_____,Member: _____

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Additional Dependent Information

NAMES OF DEPENDENTS	M/F	RELATIONSHIP	SOCIAL SECURITY NUMBER	DATE OF BIRTH	HEIGHT	WEIGHT	TOBACCO USE	EMAIL & PHONE NUMBER (for spouse and dependents 18 & older)
1.	☐ M ☐ F						☐ YES ☐ NO	
2.	☐ M ☐ F						☐ YES ☐ NO	
3.	☐ M ☐ F						☐ YES ☐ NO	
4.	☐ M ☐ F						☐ YES ☐ NO	

Additional Medical Conditions

Person	List Medical Conditions and/or specific treatments. Include any anticipated treatment or surgery.	Dates of Treatment	Medications & Dosages	Recovery Status

Additional Medical Information

Person	Medication Name	Generic RX? Yes or No	Dosage & Frequency of Use	Reason for Prescription