Effective October 1, 2023:

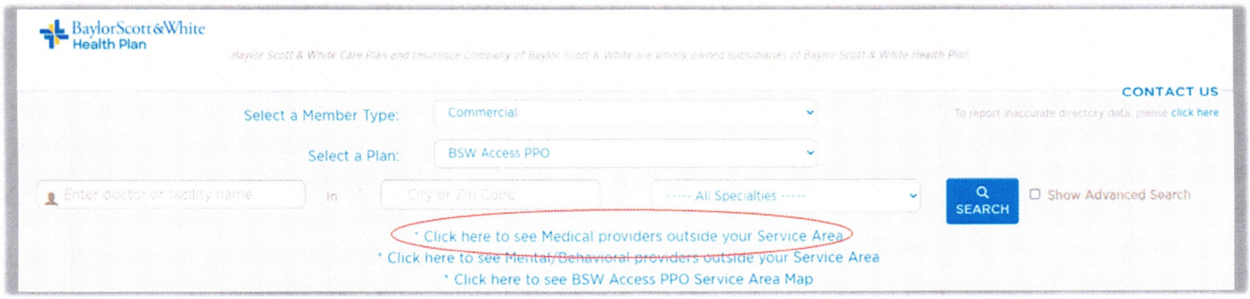
BSW Access PPO NETWORK (UnitedHealthcare) – available to members who live and/or work within the BSWHP 141 county service area.

- Plan Selection has changed to include options for BSW PPO Access Plans.
  - A group can choose up to three plans. Exception: 4 plans are allowed as long as at least one plan option is a BSW PPO Access plan.
  - We encourage the group to select a BSW PPO Access plan at renewal if they anticipate hiring someone outside of the BSWHP 141 county service area throughout the policy year. No additional plans or plan changes will be allowed mid policy year.
  - BSW Access PPO is now available to employees that live and/or work within the BSWHP 141 county service area.
  - BSW Access PPO rates are no longer the same as the BSW PPO rates.
  - Reminder: Employees who live and work outside of the BSWP 141 county service area MUST enroll on a BSW PPO Access plan.
  - *BSW Access PPO plans are still available to members that live and work outside the State of Texas.

*Please refer to Small Group Underwriting Assumptions that is included in your rate packet for eligible states outside of Texas.

Find a Provider - PPO Access:

- Go to BSWHealthPlan.com/FindProvider
- Click on "Employer Group Networks" tab
- Choose "BSW Access PPO" from the chart
- Start your search!
- To find providers outside the 141-county BSWH service area, click on "Click here to see Medical providers outside your service area." This will route to the UnitedHealthcare provider network.



Baylor Scott & White Insurance Company

Group Name	Health Guys Inc
Top Account Number	05676
Medical Rider	SP624D17
Waive New Hire During Open Enrollment	☑ Yes ☐ No

Mandatory

Group Enrollment PPO Application & Change Form

PLAN TYPE Silver PPO 70 3800

SECTION 1: REQUESTED ACTION - Check all the boxes that apply and complete the additional sections that correspond to your selection.

- Hire date is mandatory on all new enrollees and open enrollment elections.
- Late enrollees are not eligible for coverage until the next open enrollment period. Please refer to your coverage documents.
- Enrollment outside of open enrollment must have a qualifying event and be able to produce required documentation.
- To avoid delays, please ensure this application is filled out legibly and completely. Incomplete applications **will not** be processed. You can email your completed application to [HPGROUPENROLLMENT@bswhealth.org]. Please allow 5 business days for processing.

If declining coverage, complete Section 2 and 6 (If an employee is currently enrolled and does not wish to renew, the action to request is a termination, not a declination.)

Enrollment Event – Check ALL boxes that apply.

☐ Open Enrollment ☐ New Hire ☐ Current Member	Date of Hire __/__/____	**Qualifying Event?** ☐ Yes ☐ No *Select the appropriate event and enter event date. Effective date subject to SEP guidelines*		**Termination/Cancellation Date** __/__/____
❑ Rehire	Date of Rehire __/__/____	❑ Birth/Adoption **Proof of Adoption Required**	Date of birth/adoption __/__/____	❑ Terminate Contract *(Enrollee and all dependents)* ❑ Medical ❑ Dental ❑ Life
Other Changes ❑ Add Dependent(s) ❑ Change Plan Option ❑ Address Update ❑ Date of Birth ❑ Name Change ❑ COBRA Start Date __/__/____		❑ Marriage **Proof of Marriage Required**	Date of marriage __/__/____	❑ Terminate Dependent(s) Coverage *Complete Sections 4, 5, and 6*
		❑ Loss of Coverage **Proof of Loss Required**	Date coverage ended __/__/____	Reason for Termination ☐ Termination of Employment ☐ Retirement ☐ Termination of Benefits ☐ Death: Date __/__/____
		❑ Court Order **Court Order or Decree Required**	Date of order __/__/____	

SECTION 2: DECLINATION OF COVERAGE

Retain the form for your records only. The form does not need to be sent to Baylor Scott & White Insurance Company for current groups. Waivers are required for new group submissions. If an employee is currently enrolled and does not wish to renew coverage, the action requested is a termination, not a declination.

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 thirty-one (31) days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption or become party to a suit to adopt, you may enroll yourself and your dependents, provided that you request enrollment within thirty-one (31) days after the qualifying event.

☐ I decline enrollment in Baylor Scott & White Insurance Company during my initial eligibility period due to the reason listed below. **(employee) OR**

☐ I decline enrollment in Baylor Scott & White Insurance Company 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 reason for declining coverage (please specify):

SECTION 3: OTHER COVERAGE (REQUIRED)

Will you or your dependents, applying for coverage, be covered under another group health plan or Medicare? ☐ Yes ☐ No (If yes, complete below)

Insurance Company Name	Name of Policyholder _____ Policy number _____ Policy number and coverage start date __/__/____

SECTION 4: EMPLOYEE INFORMATION – All information in this section is necessary for accurate and timely processing.

Coverage Selection **Medical** ☐ Add ☐ Term ☐ Change ☐ No Change		**Dental** ☐ Add ☐ Term ☐ Change ☐ No Change			**Life** ☐ Add ☐ Term
* Social Security Number	First Name	MI	Last Name		Suffix
Mailing Address		Apt	City	State	Zip
Residential Address (If different than above)		Apt	City	State	Zip
Primary Phone	Secondary Phone	Email Address			
Employment Status ☐ Active ☐ Retiree ☐ COBRA ☐ Exempt	Marital Status ☐ Single/Divorced/Widow ☐ Married ☐ Other	☐ Male ☐ Female			Date of Birth __/__/____
Primary Spoken Language ☐ English ☐ Spanish ☐ Other (please indicate)	Written Language ☐ English ☐ Spanish ☐ Other (please indicate)				
Do you have a disability affecting your ability to communicate or read? ☐ Yes ☐ No					

SECTION 5: DEPENDENT INFORMATION – Complete all applicable information in this section.

List all family members currently active and action needed. Please complete every field in its entirety to ensure correct processing.

Medical ☐ Add ☐ Term ☐ Demographic Change ☐ No Change	First Name	MI	Last Name	Suffix
	Social Security Number	☐ Male ☐ Female	Date of Birth (MM/DD/YYYY)	
Dental ☐ Add ☐ Term ☐ Demographic Change ☐ No Change	Primary Language Spoken: ☐ English ☐ Spanish ☐ Other_____ Written ☐ English ☐ Spanish ☐ Other_____		☐ Spouse ☐ Domestic Partner* ☐ Child ☐ Grand Child ☐ Other Eligible Dependent	
	Disability affecting your ability to communicate or read? ☐ Yes ☐ No			
Medical ☐ Add ☐ Term ☐ Demographic Change ☐ No Change	First Name	MI	Last Name	Suffix
	Social Security Number	☐ Male ☐ Female	Date of Birth (MM/DD/YYYY)	
Dental ☐ Add ☐ Term ☐ Demographic Change ☐ No Change	Primary Language Spoken: ☐ English ☐ Spanish ☐ Other_____ Written: ☐ English ☐ Spanish ☐ Other_____		☐ Spouse ☐ Domestic Partner* ☐ Child ☐ Grand Child ☐ Other Eligible Dependent	
	Disability affecting your ability to communicate or read? ☐ Yes ☐ No			
Medical	First Name	MI	Last Name	Suffix

☐ Add ☐ Term ☐ Demographic Change	Social Security Number	☐ Male ☐ Female	Date of Birth (MM/DD/YYYY)	
Dental ☐ Add ☐ Term ☐ Demographic Change ☐ No Change	Primary Language Spoken: ☐ English ☐ Spanish ☐ Other Written: ☐ English ☐ Spanish ☐ Other		☐ Spouse ☐ Domestic Partner* ☐ Child ☐ Grand Child ☐ Other Eligible Dependent	
	Disability affecting your ability to communicate or read? ☐ Yes ☐ No			
Medical ☐ Add ☐ Term ☐ Demographic Change ☐ No Change	First Name	MI	Last Name	Suffix
	Social Security Number	☐ Male ☐ Female	Date of Birth (MM/DD/YYYY)	
Dental ☐ Add ☐ Term ☐ Demographic Change ☐ No Change	Primary Language Spoken: ☐ English ☐ Spanish ☐ Other Written: ☐ English ☐ Spanish ☐ Other		☐ Spouse ☐ Domestic Partner* ☐ Child ☐ Grand Child ☐ Other Eligible Dependent	
	Disability affecting your ability to communicate or read? ☐ Yes ☐ No			
Medical ☐ Add ☐ Term ☐ Demographic Change ☐ No Change	First Name	MI	Last Name	Suffix
	Social Security Number	☐ Male ☐ Female	Date of Birth (MM/DD/YYYY)	
Dental ☐ Add ☐ Term ☐ Demographic Change ☐ No Change	Primary Language Spoken: ☐ English ☐ Spanish ☐ Other Written: ☐ English ☐ Spanish ☐ Other		☐ Spouse ☐ Domestic Partner* ☐ Child ☐ Grand Child ☐ Other Eligible Dependent	
	Disability affecting your ability to communicate or read? ☐ Yes ☐ No			

SECTION 6: 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 Baylor Scott & White Insurance Company 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.

[☐ I HAVE READ AND ACCEPT THE BELOW AGREEMENT

I understand that the Certificate of Coverage, Explanation of Benefits, and other required documents, notices, and communications may be mailed or transmitted electronically to me. By completing this enrollment form, I am consenting to the electronic delivery of these communications. Consent may be withdrawn at any time by contacting Baylor Scott & White Insurance Company at [800-321-7947]. If consent is withdrawn, paper documents will be provided during the policy benefit period.]

Signature	Print Name	Date (MM/DD/YYYY)

Send completed application by one of the following methods:	
Email	[Email: HPGROUPENROLLMENT@bswhealth.org] **[Subject line: Group Name/Group Number/Division]**
Fax	[Fax 254-298-3199]
Mail	[Baylor Scott & White Insurance Company MS-A4-126 1206 West Campus Drive Temple, TX 76502]