

Effective October 1, 2023:

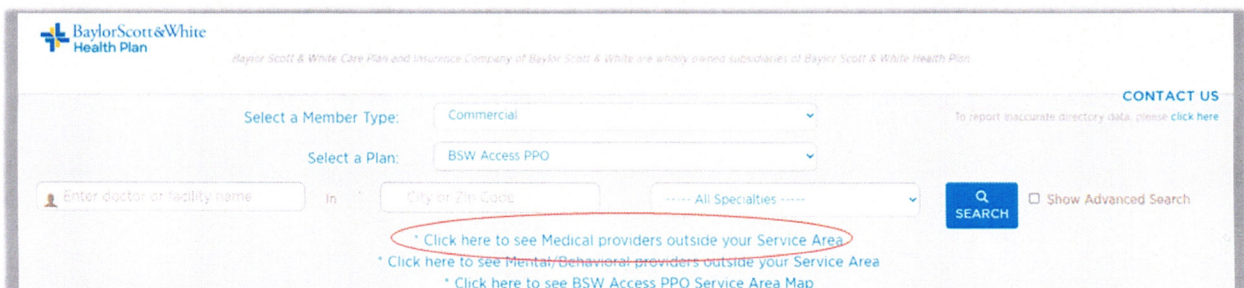
BSW Access PPO NETWORK (UnitedHealthcare) – available to members who live and/or work within the BSWHP 141 county service area.

- 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 BSWHP 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 Health Plan

Baylor Scott & White Care Plan and Insurance Company of Baylor Scott & White are wholly owned subsidiaries of Baylor Scott & White Health Plan.

Select a Member Type: Commercial

Select a Plan: BSW Access PPO

Enter doctor or facility name in City or Zip Code

----- All Specialties -----

SEARCH

CONTACT US

To report inaccurate directory data, please [click here](#)

* Click here to see Medical providers outside your Service Area

* Click here to see Mental/Behavioral providers outside your Service Area

* Click here to see BSW Access PPO Service Area Map

Group Name	Health Guys Inc.
Top Account Number	05676
Medical Rider	UAC24F17
Waive New Hire During Open Enrollment	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No

Mandatory

Group Enrollment PPO Application & Change Form PLAN TYPE Silver PPO 70 3800 Access

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.

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

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

SECTION 6: ACKNOWLEDGMENT SIGNATURE		
<p>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.</p> <p><input type="checkbox"/> I HAVE READ AND ACCEPT THE BELOW AGREEMENT</p> <p>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.]</p>		
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]