Enrollment Application/Change Form

Mail to: P.O. Box 140167, Austin, TX 78714-0169 • **Fax:** 512-719-6565

TML Health Benefits Pool

Employer Acceptance	
Date:	By:

Employer Name: _____ Group #: _____

SECTION 1: EMPLOYEE INFORMATION

Social Security #	Last Name	First Name	MI

Mailing Address	City	State	ZIP

Email Address	Gender	Marital Status	Birthdate (MM/DD/YYYY)
	☐ Male ☐ Female	☐ Single ☐ Married	

Home Phone	Mobile Phone	Work Phone

Hire Date (MM/DD/YYYY)	Job Title	Have you ever been a/an:	Employee Type
		☐ Firefighter ☐ EMT	☐ Full-Time ☐ Part-Time _____ Weekly Hours

Employee has other insurance	Other insurance carrier name	Group #	Phone #
☐ Yes ☐ No			

SECTION 2: EMPLOYEE COVERAGES ELECTIONS

	Add	Waive ◆	◆Must select below if any coverage is waived
Employee Coverage	☐ Medical* ☐ Dental ☐ Vision	☐ Medical ☐ Dental ☐ Vision	☐ Employer pays less than 60% of premium ☐ Employee covered by spouse medical plan ☐ Retiree benefits from prior engagement ☐ Enrolled in Tricare or covered by VA ☐ Enrolled in parent medical plan as dependent ☐ Enrolled in another employer medical plan ☐ Enrolled in tribal medical plan ☐ Enrolled in Medicare ☐ Enrolled in individual policy at initial enrollment period

*Medical Plan Selected:

SECTION 3: ENROLLMENT REASONS

Employee

☐ New Enrollee — Effective Date: ___/___/___
☐ Retirement — Effective Date: ___/___/___
☑ Open Enrollment — Effective Date: 10/01/21
☐ Name/Address Change — Effective Date: ___/___/___

☐ Employee Term — Last Date Worked: ___/___/___
☐ Termination due to gross misconduct
☐ Retired - Retiree Coverage Not Elected
☐ Called to Active Military Duty
☐ Employee Death
☐ Cancel/Waive Employee Coverage (Complete Section 2)
Effective Date: ___/___/___
☐ Health ☐ Dental ☐ Vision

Spouse/Dependent

☐ Add Dependent — Event Date: ___/___/___

Reason: Select event below to add dependent

☐ Birth/Adoption/Guardianship
☐ Marriage
☐ Court Order (QMCSO)
☐ Dependent Loses Other Coverage
☐ Open Enrollment
☐ Other (Explain: _____)

☐ Cancel Dependent Coverage
☐ Health ☐ Dental ☐ Vision
Event Date ___/___/___

Reason: Select event below to remove dependent

☐ Death
☐ Dependent Gains Other Coverage
☐ Divorce
☐ Open Enrollment
☐ Other (Explain: _____)

SECTION 4: SPOUSE INFORMATION AND COVERAGE ELECTIONS

☐ **ADD** ☐ **DROP**

Social Security #	Last Name	First Name	MI

Gender	Job Title	Have you ever been a/an:	Birthdate (MM/DD/YYYY)	Coverage Elections
☐ Male ☐ Female		☐ Firefighter ☐ EMT		☐ Medical ☐ Dental ☐ Vision

Spouse has other insurance	Other insurance carrier name	Group #	Phone #
☐ Yes ☐ No			

SECTION 5: DEPENDENT INFORMATION AND COVERAGE ELECTIONS

☐ **ADD** ☐ **DROP**

Social Security #	Last Name	First Name	MI

Mailing Address (if different than employee)	City	State	ZIP

Relationship
☐ Child ☐ Stepchild ☐ Foster child ☐ Legal Guardianship

Gender	Birthdate (MM/DD/YYYY)	Coverage Elections ☐ Medical ☐ Dental ☐ Vision

Dependent has other insurance ☐ Yes ☐ No	Other insurance carrier name	Group #	Phone #

☐ **ADD** ☐ **DROP**

Social Security #	Last Name	First Name	MI

Mailing Address (if different than employee)	City	State	ZIP

Relationship
☐ Child ☐ Stepchild ☐ Foster child ☐ Legal Guardianship

Gender	Birthdate (MM/DD/YYYY)	Coverage Elections ☐ Medical ☐ Dental ☐ Vision

Dependent has other insurance ☐ Yes ☐ No	Other insurance carrier name	Group #	Phone #

☐ **ADD** ☐ **DROP**

Social Security #	Last Name	First Name	MI

Mailing Address (if different than employee)	City	State	ZIP

Relationship
☐ Child ☐ Stepchild ☐ Foster child ☐ Legal Guardianship

Gender	Birthdate (MM/DD/YYYY)	Coverage Elections ☐ Medical ☐ Dental ☐ Vision

Dependent has other insurance ☐ Yes ☐ No	Other insurance carrier name	Group #	Phone #

☐ **ADD** ☐ **DROP**

Social Security #	Last Name	First Name	MI

Mailing Address (if different than employee)	City	State	ZIP

Relationship
☐ Child ☐ Stepchild ☐ Foster child ☐ Legal Guardianship

Gender	Birthdate (MM/DD/YYYY)	Coverage Elections ☐ Medical ☐ Dental ☐ Vision

Dependent has other insurance ☐ Yes ☐ No	Other insurance carrier name	Group #	Phone #

SECTION 6: COVERAGE CONDITIONS AND AUTHORIZATION

TML Health reserves the right to request proof of required eligibility documentation. The undersigned Employee affirms that (1) he or she is employed an average of at least 20 hours per week by the Employer; (2) all legal relationship(s) of a spouse and/or dependent enrolled in the Plan are based in fact and correctly represented; and (3) the dependent relationship(s) are true and correct. Employee acknowledges that the Enrollment Application / Change Form is a governmental record, and that misrepresentation of information in the enrollment form might be considered to be a felony. Employee also agrees that should coverage of a spouse and/or dependent be rescinded within federal requirements, Employee will reimburse TML Health for the amount of claims paid by TML Health for the coverage period rescinded. The employer must pay at least 60% of the employee's most cost-effective medical rate for the Pool to conduct underwriting services.

Employee Name: ______________________________ Date: __________