TML Health Benefits Pool
P.O. Box 140167
Austin, TX 78714-0169
FAX: 512-719-6565

Enrollment Application / Change Form

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: ☐ Male ☐ Female	Marital Status: ☐ Single ☐ Married	Birth Date (MM/DD/YYYY):
Home Phone:	Mobile Phone:	Work Phone:	
Hire Date (MM/DD/YYYY):	Job Title:	Employee Type: ☐ Full-Time ☐ Part-Time_____ Weekly Hours	
Employee has other insurance: ☐ Yes ☐ No	Other Insurance Carrier Name:	Group #:	Phone #:

SECTION 2 – EMPLOYEE COVERAGE 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 premiums ☐ Employee covered by spouse medical plan ☐ Retiree benefits from prior employment ☐ 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

***Medical Plan Selected:**

SECTION 3 – ENROLLMENT REASONS

EMPLOYEE

☐ New Enrollee Effective Date: _____/_____/_____
☐ Retirement Effective Date: _____/_____/_____
☐ Open Enrollment Effective Date: _____/_____/_____
☐ Name / Address Change

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:_____)

CANCELLATION REASONS

☐ 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

☐ 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: ☐ Male ☐ Female	Birth Date (MM/DD/YYYY):	Coverage Elections: ☐ Medical ☐ Dental ☐ Vision	
Spouse has other insurance: ☐ Yes ☐ No	Other Insurance Carrier Name:	Group #:	Phone #:

TML Health Benefits Pool

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 ☐ Grandchild ☐ Legal Guardian			
Gender: ☐ Male ☐ Female	Birth Date (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 ☐ Grandchild ☐ Legal Guardian			
Gender: ☐ Male ☐ Female	Birth Date (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 ☐ Grandchild ☐ Legal Guardian			
Gender: ☐ Male ☐ Female	Birth Date (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 ☐ Grandchild ☐ Legal Guardian			
Gender: ☐ Male ☐ Female	Birth Date (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 Signature Date

Mail or FAX completed form to:
TML HEALTH
P.O. BOX 140167
AUSTIN, TX 78714-0169
FAX: 512-719-6565