ADDITIONAL ENROLLMENT FORM

Payment Must Be Sent With This Form

Pool Member Information (Required for all enrollment additions)	First Name	M.I.	Last Name		
	Member ID #				
Person To Be Added Please include proof of Texas residency for the person to be added if he/she is over the age of 18. (Driver's license, voter registration card, or utility bill.)	First Name	M.I.	Last Name		
	Address	City	State	Zip	
	Telephone Number	Social Security #			
	Birth Date	Country of Birth	Relationship to Member		

Deductible Information

Plans for Non-Medicare Eligibles

- ☐ **I R $1,000 Medical Deductible, $200 Rx Deductible**
- ☐ **II R $2,500 Medical Deductible, $200 Rx Deductible**
- ☐ **III R $5,000 Medical Deductible, $200 Rx Deductible**
- ☐ **IV R $7,500 Medical Deductible, $500 Rx Deductible**
- ☐ **V R HDHP/ HSA-Qualified, $3,000 Medical Deductible, $1,250 Rx Deductible**

Plans for Medicare Eligibles

- ☐ **I M $1,000 Medical Deductible, (No Rx Benefit)**
- ☐ **II M $2,500 Medical Deductible, (No Rx Benefit)**

Smoker Status

Smoked cigarettes, cigars, or a pipe or used chewing tobacco, nicotine chewing gum or snuff in the last twelve (12) months? ☐ Yes ☐ No

Payment Method

The payment method will be the same as the current member.

Employment Information

If person to be added is employed or self-employed, you must provide the **Employment Verification Form** or the **Self-Employment Verification Form**, as applicable.

☐ Employed ☐ Self-employed ☐ Unemployed/retired

If unemployed or retired, date last employment ended: _____

If unemployed or retired less than 18 months, provide last employer name: _____

_____ and telephone number _____.

I hereby certify that the foregoing statements are true and accurate to the best of my knowledge and belief. I understand that no coverage will be effective for the person named above until this enrollment form is approved and any required additional premium is received. I understand that if I or any person covered by this policy no longer meets Pool eligibility requirements, the Pool Administrator must be notified and Pool coverage will end.

Signature of Member Date	Signature of Parent or Legal Guardian Date (If Member is under age 18 or legally incompetent)

Mail this form to: Texas Health Insurance Pool
P. O. Box 660819
Dallas, TX 75266

Questions? Call: 1-888-39-TEXAS (1-888-398-3927)
Fax: 1-325-793-4134
Website: www.txhealthpool.org