



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				
	<input type="checkbox"/> I R \$1,000 Medical Deductible, \$200 Rx Deductible <input type="checkbox"/> II R \$2,500 Medical Deductible, \$200 Rx Deductible <input type="checkbox"/> III R \$5,000 Medical Deductible, \$200 Rx Deductible <input type="checkbox"/> IV R \$7,500 Medical Deductible, \$500 Rx Deductible <input type="checkbox"/> V R HDHP/ HSA-Qualified, \$3,000 Medical Deductible, \$1,450 Rx Deductible				
	Plans for Medicare Eligibles				
	<input type="checkbox"/> I M \$1,000 Medical Deductible, (No Rx Benefit) <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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.	<input type="checkbox"/> employed <input type="checkbox"/> self-employed <input type="checkbox"/> 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