MediExcel HEALTH PLAN

+ MEDICAL/DENTAL/VISION COVERAGE ENROLLMENT FORM

E-mail: applications@mediexcel.com **Telephone:** (619) 421-1659 **www.mediexcel.com**

*****HR, PLEASE FILL IN SHADED AREA OF APPLICATION BELOW*****

☐ **New Group** ☐ **Renewal** ☐ **New Hire** ☐ **Add Dependent**

Group Name or Number: _____

Effective Date: _____

☐ **Personal Information Update**

☐ **Term Employee** ☐ **Term Dependent (s) Only**

Term Effective Date: _____

Reason for Term: ☐ **Voluntary** ☐ **Involuntary**

☐ **Death** ☐ **Seasonal** ☐ **Dissatisfied**

EMPLOYEE INFORMATION

Last Name	First Name		Birthdate (MM/DD/YYYY)	
Street Address	**City**	**State**	**Zip Code**	**Country**

Gender Identity	Social Security #	Telephone Number	Emergency Telephone Number
☐ Male ☐ Female ☐ Non-Binary	__ __ __ • __ __ • __ __ __ __	(__ __ __) __ __ __ • __ __ __ __	(__ __ __) __ __ __ • __ __ __ __

Please provide e-mail to receive carrier updates: _____

Marriage Status	Select Your Plans	Preferred Language	Preferred Region	Download the MediExcel App from Google Play or the Apple App store!
☐ Single ☐ Married ☐ Domestic Partnership	☐ Medical _____ ☐ Dental _____ ☐ Vision	☐ Spanish ☐ English	☐ Tijuana ☐ Mexicali	GET IT ON Google Play / Download on the App Store

DEPENDENT INFORMATION – IF YOU ARE COVERING YOUR DEPENDENTS, COMPLETE THE FOLLOWING SECTION. ATTACH ANOTHER SHEET IF NEEDED.

Last Name	First Name	Birthdate	Gender	Social Security #	Select Your Plans
Spouse/Domestic Partner			☐ Male ☐ Female ☐ Non-Binary		☐ Medical ☐ Dental ☐ Vision
Dependent			☐ Male ☐ Female ☐ Non-Binary		☐ Medical ☐ Dental ☐ Vision
Dependent			☐ Male ☐ Female ☐ Non-Binary		☐ Medical ☐ Dental ☐ Vision
Dependent			☐ Male ☐ Female ☐ Non-Binary		☐ Medical ☐ Dental ☐ Vision

OTHER MEDICAL COVERAGE

SIGNATURE REQUIRED: By signing below, I acknowledge I have read, understand, and agree to the terms and arbitration agreement stated below.

A. On behalf of myself and my eligible Dependents, I hereby apply for health coverage offered by MediExcel Health Plan through my Employer and agree to be bound by the MediExcel Health Plan Group Subscriber Agreement, Evidence of Coverage and Disclosure Form, and this Enrollment Form.

B. I attest the information provided in this application is true and complete.

C. I attest that I and my enrolling dependents (*if applicable*) have the necessary travel documents to cross into Mexico to access healthcare.

D. **MANDATORY BINDING ARBITRATION:** **I understand** that MediExcel Health Plan uses mandatory binding arbitration to resolve disputes. I am agreeing to arbitrate claims that relate to my or a dependent's membership in MediExcel Health Plan (*except for small claims court cases and claims that cannot be subject to binding arbitration under governing law.*) **I understand** that any dispute between myself, my heirs, relatives, or other associated parties, and MediExcel Health Plan, any contracted health care providers, administrators, or other associated parties for alleged violation of any duty arising out of or related to membership in the health plan, including any claim for medical or hospital malpractice, (*a claim that medical services were unnecessary or unauthorized or were improperly, negligently or incompletely rendered*) for premises liability, or relating to the coverage for, or delivery of, services or items, irrespective of legal theory, must be decided by binding arbitration under California law and not by lawsuit or resort to court process, except as applicable law provides for judicial review of arbitration proceedings. **I agree** to give up our right to a jury trial and accept the use of binding arbitration. **I understand** that the full arbitration provision is in the MediExcel Health Plan Evidence of Coverage, which is available for my review.

E. I agree to receive Plan Documents, Notices, (*EOC, SBC, Tax Forms*) Announcements, Surveys, in an electronic digital format rather than a hard copy from MediExcel Health Plan, starting no later than 1/1/2022. **I understand** I have the right to change this preference at any time for any reason by contacting Member Services.

Employee Signature X _____ Date X _____

CALIFORNIA LAW PROHIBITS ANY HIV TEST FROM BEING REQUESTED OR USED BY HEALTHCARE SERVICE PLANS AS A CONDITION FOR OBTAINING HEALTH COVERAGE