MEDICAL/DENTAL/VISION COVERAGE ENROLLMENT FORM

HR, PLEASE FILL IN SHADED AREA AND EMAIL COMPLETED APPLICATION TO APPLICATIONS@MEDIEXCEL.COM

☐ New Hire ☐ Existing Employee	☐ Adding Dependent	☐ Term Employee ☐ Term Dependent (s) Only
Group Name or Number:	☐ Personal Information Update	**Term Effective Date:** _____
Date of Hire: _____ *(enrollment must align with waiting period)*	☐ Qualifying Event *(proof may be required)*	**Reason for Term:** ☐ Voluntary ☐ Involuntary
	Date of Qualifying Event: _____	☐ Death ☐ Seasonal ☐ Dissatisfied

EMPLOYEE INFORMATION (**ALL FIELDS REQUIRED**)

Last Name	First Name	Date of Birth (MM/DD/YYYY)		
Address / Apt. #	City	State	Zip Code	Country
E-Mail Address	☐ *I understand that all communication, including documents and/or notices regarding my health plan coverage, are sent electronically, and as such, I am required to provide a valid and current e-mail address.*			

Do you or your dependents have other health coverage? Employee ☐ Yes ☐ No Dependents ☐ Yes ☐ No If yes, answer below:

Name of other insurance company: _____ Member Number: _____

Social Security #	Gender Identity	Marital Status	Enrolling in	Preferred Language	Preferred Region
___ ___ ___ - ___ ___ - ___ ___ ___ ___	☐ Male	☐ Single	☐ Medical _____	☐ Spanish	☐ Tijuana
Telephone # ( ) -	☐ Female	☐ Married	☐ Dental _____	☐ English	☐ Mexicali
Emergency Telephone # ( ) -	☐ Non-Binary	☐ Domestic Partnership	☐ Vision		☐ Tecate

DEPENDENT INFORMATION – IF YOU ARE ADDING DEPENDENTS TO YOUR POLICY, PLEASE COMPLETE THE SECTION BELOW. IF MORE SPACE IS NEEDED, PLEASE ATTACH ANOTHER SHEET.

Last Name	First Name	Date of Birth (MM/DD/YYYY)	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

ACKNOWLEDGMENT

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. By signing this enrollment form, **I agree** to receive all Plan Documents, Notices, (*EOC, SBC, Tax Forms, Out-of-Pocket Accrual & Deductible Balances*) in electronic form, as well as announcements, surveys and/or appointment reminders via e-mail or text. **I understand** I have the right to change this preference at any time 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*****