



+ MEDICAL/DENTAL/VISION COVERAGE ENROLLMENT FORM

E-mail completed application to: applications@mediexcel.com

For questions call: (619) 421-1659

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

<input type="checkbox"/> New Hire <input type="checkbox"/> Existing Employee Group Name or Number: _____ Date of Hire: _____ <small>(enrollment must align with waiting period)</small>	<input type="checkbox"/> Adding Dependent <input type="checkbox"/> Personal Information Update <input type="checkbox"/> Qualifying Event <small>(proof may be required)</small> Date of Qualifying Event: _____	<input type="checkbox"/> Term Employee <input type="checkbox"/> Term Dependent (s) Only Term Effective Date: _____ Reason for Term: <input type="checkbox"/> Voluntary <input type="checkbox"/> Involuntary <input type="checkbox"/> Death <input type="checkbox"/> Seasonal <input type="checkbox"/> Dissatisfied
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EMPLOYEE INFORMATION

Last Name	First Name	Date of Birth (MM/DD/YYYY)		
Street Address	Apt. #	City	State	Zip Code
Country				
Do you or any of your dependents have any other health coverage? Employee <input type="checkbox"/> Yes <input type="checkbox"/> No Dependents <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please answer below:				
Name of insurance company: _____ Member Number: _____				

Please provide your e-mail to receive plan updates: _____

Social Security #: ____ - ____ - _____	Gender Identity	Marriage Status	Enrolling In	Preferred Language	Preferred Region
Telephone #: () -	<input type="checkbox"/> Male	<input type="checkbox"/> Single	<input type="checkbox"/> Medical _____	<input type="checkbox"/> Spanish	<input type="checkbox"/> Tijuana
Emergency Telephone #: () -	<input type="checkbox"/> Female	<input type="checkbox"/> Married	<input type="checkbox"/> Dental _____	<input type="checkbox"/> English	<input type="checkbox"/> Mexicali
	<input type="checkbox"/> Non-Binary	<input type="checkbox"/> Domestic Partnership	<input type="checkbox"/> Vision		

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

Last Name	First Name	Date of Birth (MM/DD/YYYY)	Gender	Social Security #	Select Your Plans
Spouse/Domestic Partner			<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Non-Binary		<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision
Dependent			<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Non-Binary		<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision
Dependent			<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Non-Binary		<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision
Dependent			<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Non-Binary		<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> 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. I agree to receive Plan Documents, Notices, *(EOC, SBC, Tax Forms, Out-of-Pocket Accrual & Deductible Balances)* 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*****