



MEDICAL/DENTAL/VISION COVERAGE ENROLLMENT FORM

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

<input type="checkbox"/> New Hire	<input type="checkbox"/> Existing Employee	<input type="checkbox"/> Adding Dependent	<input type="checkbox"/> Term Employee	<input type="checkbox"/> Term Dependent (s) Only
Group Name or Number:		<input type="checkbox"/> Personal Information Update	Term Effective Date: _____	
Date of Hire: _____ (enrollment must align with waiting period)		<input type="checkbox"/> Qualifying Event (proof may be required)	Reason for Term: <input type="checkbox"/> Voluntary <input type="checkbox"/> Involuntary	
		Date of Qualifying Event: _____	<input type="checkbox"/> Death <input type="checkbox"/> Seasonal <input type="checkbox"/> 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				<input type="checkbox"/> 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 <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Non-Binary	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Domestic Partnership	Enrolling in <input type="checkbox"/> Medical _____ <input type="checkbox"/> Dental _____ <input type="checkbox"/> Vision	Preferred Language <input type="checkbox"/> Spanish <input type="checkbox"/> English	Preferred Region <input type="checkbox"/> Tijuana <input type="checkbox"/> Mexicali <input type="checkbox"/> Tecate
Telephone # () - -					
Emergency Telephone # () - -					

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			<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.

- 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.
- I attest the information provided in this application is true and complete.
- I attest that I and my enrolling dependents (if applicable) have the necessary travel documents to cross into Mexico to access healthcare.
- 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.
- 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*****