PREMIUM ASSISTANCE PROGRAM
Employee Application & Enrollment Form

1. All fields must be complete **2. Please print all answers.**

Section I: EMPLOYEE INFORMATION

Employee Last Name	Employee First Name	Maiden Name (if applicable)	Social Security Number

Birthdate (MM/DD/YYYY)	Gender (M/F)	Ethnicity/Race (optional)	Name of Spouse	Average hours/week

Home Street Address	City	ZIP Code	County	Marital Status (circle one) M S D W

Mailing address (if different from above)	Cell Number (required)	Personal Email (required)

Employer	Hire Date	Employer Contact Person	Employer Address

Section II: APPLICATION CERTIFICATION

This application is for health insurance premium assistance from TexHealth Central Texas. To waive participation, check the first box, skip to the signature line and sign the form. Otherwise, read and check each box before signing to indicate agreement.

☐ I **waive participation** in the TexHealth Premium Assistance Program. (Skip to signature line).

☐ I certify that to the best of my knowledge the information I have given in my application is true, complete and correct.
☐ I understand that any contract for health coverage based on false or incomplete information is prohibited by law and my participation in the premium assistance program may be voided by TexHealth Central Texas.
☐ I give my permission to TexHealth Central Texas or its agent to contact persons or agencies to obtain needed information about me.
☐ I agree that TexHealth Central Texas' premium assistance has been fully explained to me and I understand it and acknowledge it is subject to change in the sole discretion of TexHealth.
☐ I understand that my employer is using an insurance agent and insurance company and I authorize TexHealth Central Texas or its agent to release information to my employer and/or employer's agent for purposes of this application.
☐ I certify I am not receiving any government health benefits such as Medicaid or Medicare.
☐ I understand that as a condition of my participation with TexHealth's Premium Assistance Program, I will notify TexHealth or a TexHealth representative within 48 hours of any changes in my health insurance status or health insurance company.

My current insurance company is: _____,

Effective date of coverage_____.

My **Total income** from this business is $_____.00 **per month** or $_____.00 **per year**.

By signing below I understand TexHealth Central Texas is not an insurer and cannot be held responsible for any acts or omissions by my insurance company, its agent(s) or my employer's insurance agent.

Signature of Employee _____ **Date Signed** _____

Witness Signature_____ **Date Signed**_____