PREMIUM ASSISTANCE PROGRAM
Employee Application & Enrollment Form

1. All FIELDS must be complete **2. ELECTRONIC SUBMISSION ONLY**

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. By checking the Second box I certify I have read and AGREE with each statement.

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

☐ I certify that to the best of my knowledge that all the below statements are true and the information I have given in my application is true, correct and complete.

☐ 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 as a result.

☐ I give my permission to TexHealth or its agent to contact persons or agencies to obtain needed information about me.

☐ I agree that TexHealth 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 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 Medicaid or Medicare Part B.

☐ 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 Employment status.

My current insurance company is

Effective date of coverage

My **Total income** from this business is ○ **per month** or ◉ **per year**. _____

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

Signature of Employee _____ **Date Signed** _____

Witness Signature_____ **Date Signed**_____