

## **PREMIUM ASSISTANCE PROGRAM Employee Application & Enrollment Form**

	Employee F	irst l	Name				Social S	Security Number
		Employee First Name			Maiden Name (if applicable)		Social Security Number	
/DD/YYYY) Gender (M/F) Ethnicity/I (optional)		ace Name		Name o	of Spouse		Average hours/week	
Home Street Address City		ZIP Code		9	County		Marital Status (circle one)  M S D W	
Mailing address (if different from above)		Cell Number		r (required)		Personal Email (req	onal Email (required)	
Employer H		Employer Contact Per		rson	Employer Address			
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To waive esignature line and sign the form. By checking the Second box I certify I have pation in the TexHealth Premium Assistance Program. (Skip to signature on is correct and complete. (PLEASE CHECK EACH BOX BELOW) ye participation in the premium assistance program may be voided as a condition to TexHealth or its agent to contact persons or agencies to obtain e.  CHealth premium assistance has been fully explained to me and I under to change in the sole discretion of TexHealth. Insurance companient or release information to my employer and/or employer's agent as a condition of my participation with TexHealth's Premium Assistance as a TexHealth representative within 48 hours of any changes in my healt as a company is

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