+ MEDICAL/DENTAL/VISION COVERAGE ENROLLMENT FORM

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

☐ **New Group** ☐ **Renewal** ☐ **New Hire** ☐ **Add Dependent**	☐ **Term Employee** ☐ **Term Dependent (s) Only**
Group Name or Number: ________________________________	**Term Effective Date:**________________
Effective Date: _____________	**Reason for Term:** ☐ **Voluntary** ☐ **Involuntary**
☐ **Personal Information Update**	☐ **Death** ☐ **Seasonal** ☐ **Dissatisfied**

EMPLOYEE INFORMATION

Last Name	First Name		Birthdate (MM/DD/YYYY)	
Street Address	City	State	Zip Code	Country

Gender	Social Security #	Telephone Number	Emergency Telephone Number
☐ M ☐ F ☐ I identify as: __________	___ • __ • ____	(___) ___ • ____	(___) ___ • ____

Please provide e-mail to receive carrier updates:____

Marriage Status	Select Your Plans	Preferred Language	Preferred Region	
☐ Single ☐ Married ☐ Domestic Partnership	☐ Medical ____________ ☐ Dental ____________ ☐ Vision	☐ Spanish ☐ English	☐ Tijuana ☐ Mexicali	Download the MediExcel App from Google Play or the Apple App store!

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

Last Name	First Name	Birthdate	Sex M/F	Social Security #	Select Your Plans
Spouse/Domestic Partner					☐ Medical ☐ Dental ☐ Vision
Dependent					☐ Medical ☐ Dental ☐ Vision
Dependent					☐ Medical ☐ Dental ☐ Vision
Dependent					☐ Medical ☐ Dental ☐ Vision

OTHER MEDICAL COVERAGE

SIGNATURE REQUIRED: By signing below, I acknowledge that 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 on the one hand and MediExcel Health Plan, any contracted health care providers, administrators, or other associated parties on the other hand 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.

Employee Signature X ____ Date X ______________________________

CALIFORNIA LAW PROHIBITS ANY HIV TEST FROM BEING REQUESTED OR USED BY HEALTHCARE SERVICE PLANS AS A CONDITION OF OBTAINING HEALTH COVERAGE