



Texas Children's
Health Plan

Mail or fax to:
Managed Care Marketing
PO Box 8667, The Woodlands, TX 77387-8667
ph# 936-321-6286 fax# 936-321-4228

Individual Medical Coverage

ENROLLMENT APPLICATION

Parent/Guardian (name of adult completing the application on behalf of the child(ren))

Last name, first name, middle initial Relationship to children Social Security #

Street address (include apartment #) City Zip code County

Home phone Work phone E-mail address

Primary language spoken Does parent/guardian have any special communication needs? (Are they blind, hearing-impaired, etc.)? If so, please explain.

Other parent or guardian Relationship to children

Child to be insured (#1)

Last name, first name, middle initial Sex Birthdate Height Weight

Street Address Social Security # Primary care physician (PCP) selected

Name and phone of physician who has most recently seen this child Reason for last visit Last visit (mo/yr) Current medications child is taking

Child to be insured (#2)

Last name, first name, middle initial Sex Birthdate Height Weight

Street Address Social Security # Primary care physician (PCP) selected

Name & phone of physician who has most recently seen this child Reason for last visit Last visit (mo/yr) Current medications child is taking

Child to be insured (#3)

Last name, first name, middle initial Sex Birthdate Height Weight

Street Address Social Security # Primary care physician (PCP) selected

Name & phone of physician who has most recently seen this child Reason for last visit Last visit (mo/yr) Current medications child is taking



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MEDICAL HISTORY

Complete the following for all children to be covered. Check "yes" if the children have had surgery, diagnosis or treatment for – or symptoms of – any of the following conditions. If any answer is "yes", explain for each child on the next page under Additional Medical Details. Any misrepresentation or omission regarding the presence of any illnesses, impairments, diseases and conditions which existed prior to the date on this application, or any other material misrepresentation in this application, may result in the coverage being voided back to the date of inception of coverage.

	Yes	No
1. Disorder of the eyes, ears, vision, nose or throat?	<input type="checkbox"/>	<input type="checkbox"/>
2. Asthma, reactive airway disease, allergies, bronchitis, pneumonia, sinus, nasal, tonsil, adenoids, bronchi, trachea, trouble breathing, lung or other respiratory symptoms or disorder of the lungs or respiratory system?	<input type="checkbox"/>	<input type="checkbox"/>
3. Stomach, throat (swallowing), esophagus, ulcers, intestine, hernia, rectal or digestive disorder?	<input type="checkbox"/>	<input type="checkbox"/>
4. Gallbladder, hepatitis, jaundice or other liver disease?	<input type="checkbox"/>	<input type="checkbox"/>
5. Abnormal growth or function of thyroid, pancreas, adrenal, lymph glands or diabetes?	<input type="checkbox"/>	<input type="checkbox"/>
6. Heart trouble, heart defect, murmur or other blood vessel (circulation) problems?	<input type="checkbox"/>	<input type="checkbox"/>
7. Kidney, bladder, prostate, reproductive organs, menstrual disturbance or other male/female disorder?	<input type="checkbox"/>	<input type="checkbox"/>
8. Arthritis, polio, rheumatic fever?	<input type="checkbox"/>	<input type="checkbox"/>
9. Back, muscle, bone, joint, spine, neck injury, fracture, deformity or disorder of any part of the skeletal system?	<input type="checkbox"/>	<input type="checkbox"/>
10. Epilepsy, convulsions, seizures, headaches, fainting, paralysis or other diseases of the brain and nervous system?	<input type="checkbox"/>	<input type="checkbox"/>
11. Skin disorder or fungus infections?	<input type="checkbox"/>	<input type="checkbox"/>
12. Cancer, leukemia, Hodgkin's disease, melanoma or Kaposi's sarcoma?	<input type="checkbox"/>	<input type="checkbox"/>
13. Tumor, cyst or growth (benign or malignant)?	<input type="checkbox"/>	<input type="checkbox"/>
14. Blood transfusions or other blood disorders or anemia?	<input type="checkbox"/>	<input type="checkbox"/>
15. Tested positive for HIV or diagnosed with acquired immune deficiency syndrome (AIDS), with or without symptoms?	<input type="checkbox"/>	<input type="checkbox"/>
16. Behavioral, emotional, psychological or mental disorders, depression, attention-deficit disorder, hyperactivity, anorexia or bulimia, or received psychiatric treatment and counseling?	<input type="checkbox"/>	<input type="checkbox"/>
17. Congenital abnormality or disease?	<input type="checkbox"/>	<input type="checkbox"/>
18. Genetic/metabolic abnormality or disease?	<input type="checkbox"/>	<input type="checkbox"/>
19. Developmental abnormality or disorder? Any form of Autistic disorders?	<input type="checkbox"/>	<input type="checkbox"/>
20. Any therapies needed (speech, physical or occupational)?	<input type="checkbox"/>	<input type="checkbox"/>
21. Alcohol or drug abuse, dependence, addiction or treatment? Any smoking or use of tobacco products?	<input type="checkbox"/>	<input type="checkbox"/>
22. Other mental or physical injury, deformity, disease, condition, defect or disorder not listed above?	<input type="checkbox"/>	<input type="checkbox"/>
23. Other medical or surgical advice, diagnosis, treatment, abnormal test results or hospitalization?	<input type="checkbox"/>	<input type="checkbox"/>
24. Chronic or recurring minor ailments, injuries or other departures from good health, regardless of whether a physician was consulted?	<input type="checkbox"/>	<input type="checkbox"/>
25. Diagnostic testing, treatment or surgery discussed, recommended or scheduled that has not been performed?	<input type="checkbox"/>	<input type="checkbox"/>
26. Is the child to be covered pregnant or has ever been pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
27. Has this child had consultation, or been treated or examined by any physician/healthcare provider or home healthcare provider for any reason not already named?	<input type="checkbox"/>	<input type="checkbox"/>

Records Required with Application
If a child is younger than 3 years old, include a complete copy of the child's medical record from all doctors he/she has seen; or have the pediatrician complete a pediatrician's statement.



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