

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Wholesaling Industry Health Trust Employee Enrollment and Change Form** | | | | | | | | | | | | | | | | |
| Employer Name | | | Effective Date      /     /Date of Hire      /     / **Hours Worked Per Week** | | | | | **Qualifying Event Description Event Date:      /     /**  Hire/Rehire  Birth/Adoption  Marriage/DP Open Enrollment COBRA Loss of Coverage  Court Order Name Change  New Address  Beneficiary  Other \_\_\_\_\_\_\_\_\_\_\_\_  Termination | | | | | | | | | |
| **EMPLOYEE INFORMATION** ***(\*indicates required field)*** | | | | | | | | | | | | | | | | | |
| \*First Name, Middle Initial, Last Name | | | | Marital Status  Married: Single: | | | | | \*Date of Birth  **/****/** | | | | \*Gender | | \*Social Security # | | |
| M | F |
| \*Mailing Address: City, State, Zip | | | | \*Employee Email Address | | | | | | | \*Phone Number | | | | Annual Salary | Employee Class | |
| DEPENDENT INFORMATION (*\*indicates required field)* | | | | | | | | | | | | | | | | | |
| **\*Add or**  **Delete**  (Circle One) | **\*Name of Dependent**  (If dependent has different mailing address, please attach)  First name, Middle initial, Last name | | | | **\*Birth Date**  (Children age 26 or over require disability certification) | | | | | **\*Gender**  (Circle One) | | **\*Social Security #** | | | | | |
|
| Add/Delete | Spouse/Registered Domestic Partner | | | | **/**     **/** | | | | | M  F | |  | | | | | |
| Add/Delete | Child | | | | **/**     **/** | | | | | M  F | |  | | | | | |
| Add/Delete | Child | | | | **/**     **/** | | | | | M  F | |  | | | | | |
| Add/Delete | Child | | | | **/**     **/** | | | | | M  F | |  | | | | | |
| Add/Delete | Child | | | | **/**     **/** | | | | | M  F | |  | | | | | |
| **For individuals who are eligible for enrollment in an employer group health plan:** If you are declining enrollment for yourself or your dependents (including your spouse/domestic partner) because of other health insurance or employer group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if, in the case of employer group health plan coverage, the employer stops contributing toward you or your dependents’ other coverage.) However, you should request enrollment within 60 days after you or your dependents’ other coverage ends (or after the employer stops contributing toward the other coverage). In addition, if you gain a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you should request enrollment within 60 days of the marriage, birth, adoption, or date of assumption of total or partial legal obligation for support of a child in anticipation of adoption. Dependents are not required to reside with the subscriber. Dependents are not required to be dependent upon the subscriber for support. Eligibility for medical assistance is not considered when determining eligibility for coverage or making payments. Dependent children are eligible for coverage through the age of 25 regardless of marital status, student status or eligibility for coverage under another plan. Washington State Registered Domestic Partners are treated the same as a spouse. If children of the primary insured are covered, children of Domestic Partners are eligible for coverage on the same basis. | | | | | | | | | | | | | | | | | |
| PLAN SELECTIONS | | |  | | | | | | | | | | | | | | | |
| Medical and Prescription Drug (Rx) Plan Selection | | | **Employee**  **Employee and Spouse/Domestic Partner**  **Employee and Child(ren)**  **Family**  Please see your employer for plan details. Common enrollment is required for all lines of coverage.  ***If no coverage selected, attach waiver form.*** | | | | | | | | | | | | | | | |
| Dental Plan Selection fromDelta Dental of Washington | | | **Employee**  **Employee and Spouse/Domestic Partner**  **Employee and Child(ren)**  **Family**  Please see your employer for plan details. | | | | | | | | | | | | | | | |
| **Vision Plan** from VSP Vision Care Inc. | | | **Employee**  **Employee and Spouse/Domestic Partner**  **Employee and Child(ren)**  **Family**  Please see your employer for plan details. | | | | | | | | | | | | | | | |
| **Voluntary Life** from LifeMap Assurance Company  Please see your employer for plan details. | | | If offered by your Employer, you may elect $20,000 or $40,000 guarantee issue in voluntary life insurance for yourself. Additional amounts require evidence of insurability. Premium will be payroll deducted.  **Employee:**  $20,000  $40,000 $60,000\*  $80,000\*  $100,000\* \**Requires Evidence of Insurability*  **Use the rate table below to determine your monthly cost.**   |  |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | | Age | Under 30 | 30-34 | 35-39 | 40-44 | 45-49 | 50-54 | 55-59 | 60-64 | 65-69 | 70-74 | 75+ | | Rate for $20,000 | 2.00 | 2.20 | 2.60 | 4.80 | 8.40 | 14.20 | 24.40 | 28.20 | 49.60 | 87.00 | 133.00 | | Rate for $40,000 | 4.00 | 4.40 | 5.20 | 9.60 | 16.80 | 28.40 | 48.80 | 56.40 | 99.20 | 174.00 | 266.00 | | Rate for $60,000 | 6.00 | 6.60 | 7.80 | 14.40 | 25.20 | 42.60 | 73.20 | 84.60 | 148.80 | 261.00 | 399.00 | | Rate for $80,000 | 8.00 | 8.80 | 10.40 | 19.20 | 33.60 | 56.80 | 97.60 | 112.80 | 198.40 | 348.00 | 532.00 | | Rate for $100,000 | 10.00 | 11.00 | 13.00 | 24.00 | 42.00 | 71.00 | 122.00 | 141.00 | 248.00 | 435.00 | 665.00 | | | | | | | | | | | | | | | | |
| **Voluntary Personal Accident**  National Union Fire Insurance Company of Pittsburgh, Pa. (an AIG Company) | | | Please see your employer for plan details | | | | | | | | | | | | | | | |
| **Beneficiary Information** | | | | | | | | | | | | | | | | | | |
| **Beneficiary Information: (Mandatory) Compulsory 15K Policy w/ Medical** | | | Primary Beneficiary Name and Relationship\* | | | | | Primary Beneficiary Address | | | | | | | | | | |
| Contingent Beneficiary Name and Relationship\*\* | | | | | Contingent Beneficiary Address | | | | | | | | | | |
| \* If more than one primary beneficiary is named, the primary beneficiaries shall share equally unless otherwise indicated above. \*\* Contingent Beneficiary (ies) will only receive proceeds if all Primary Beneficiaries have predeceased the Insured. If you are naming more than one Contingent Beneficiary at 100% each, please indicate them in order of precedence. | | | | | | | | | | | | | | | | | | |
| **Employee and Employer Signature:**  I hereby apply for enrollment or change of enrollment as indicated on this application. I understand that the Trust and the Insurers may collect, use and disclose protected health information about each individual enrolled under this application in order to carry out their routine business functions, including but not limited to, determining eligibility for benefits, paying claims, coordinating benefits with other insurance carriers or payer, underwriting and conducting case management care management and quality reviews. The Trust and the Insurers may also disclose protected health information to state and federal agencies, or other third parties, as required by law. I understand that information collected in connection with administration of the benefit plan may be used to bring to my attention health products or services that might be valuable to me and otherwise as permitted by law. It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.  I acknowledge and understand my health plan may request or disclose health information about me or my dependents (persons who are eligible for benefits coverage and are listed on the enrollment form) for the purpose of facilitating health care treatment, payment or for the purpose of business operations necessary to administer health care benefits; or as required by law.\* Health information requested or disclosed may be related to treatment or services performed by: a physician, dentist, pharmacist or other physical or behavioral health care practitioner; a clinic, hospital, long term care or other medical facility; any other institution providing care treatment, consultation, pharmaceuticals or supplies; or an insurance carrier or group health plan. Health information requested or disclosed may include, but is not limited to: claims records, correspondence, medical records, billing statements, diagnostic imaging reports, laboratory reports, dental records, or hospital records (including nursing records and progress notes). This acknowledgement does not apply to obtaining information regarding psychotherapy notes. A separate authorization will be used for psychotherapy notes. I authorize my employer to deduct from my earnings the amount, if any, for the coverage selected. \*For more information about such uses and disclosures, including uses and disclosures required by law, please refer to the Notice of Privacy Practices. A copy is available from the appropriate Endorsed Carrier listed below. | | | | | | | | | | | | | | | | | |
| Employee Signature and Date (Required for all Adds/Changes to enrollment)    Employee email address (for electronic notifications): | | | | | | Employer Signature and Date | | | | | | | | | | | |
| Endorsed Carrier Contact Information | | | | | | | | | | | | | | | | | |
| Kaiser Foundation Health Plan of Washington: 601 Union St. Suite 3100, Seattle WA 98101: Customer Service – 888.901.4636  Kaiser Foundation Health Plan of Washington Options: 601 Union St. Suite 3100, Seattle WA 98101: Customer Service – 888.901.4636  Delta Dental of Washington: 400 Fairview Avenue North, Suite 800, Seattle, WA 98109: Customer Service – 800.554.1907  VSP Vision Care Inc.: 3333 Quality Drive Rancho Cordova, CA 95670: Customer Service – 800.877.7195  LifeMap Assurance Company®: 100 S.W. Market St., M/S E8L., Portland, OR 97207-5702: Customer Service – 800.794.5390  Wellspring EAP: 1900 Rainier Ave. South, Seattle, WA 98144: Customer Service – 800.553.7798  National Union Fire Insurance Company of Pittsburgh, Pa. (an AIG Company): 175 Water St. 18th Floor; New York, NY 10038: Customer Service – 212.770.7000 | | | | | | | | | | | | | | | | | |
| **For Employer Use Only**  **Please send applications to: Vimly Benefits Solutions BHT Admin. PO Box 6, Mukilteo, WA 98275 Email: bht@vimly.com**  **Kaiser Foundation Health Plan of Washington HMO Products**:  $200  $500  $750  $1000  $2000  $3000  $5000  HSA $2500  HSA $4500  **Kaiser Foundation Health Plan of Washington Options PPO Products**:  $200  $500  $750  $1000  $5000  $2000  $3000  $5000  HSA $2500  HSA $4500  **Delta Dental of Washington:**  Plan 1  Plan 2  Plan 3  Plan 4  Plan 5  Plan 6  Child Orthodontia Rider  Family Orthodontia Ride  **VSP Vision Care Inc.:**  Choice Plan A  Choice Plan B  Choice Plan C  **Wellspring EAP:**  Buy up option – 6 Visit  **LifeMap Assurance Company Voluntary Life:**   Yes  No  **National Union Fire Insurance Company of Pittsburgh, Pa. (an AIG Company) Voluntary Personal Accident:** Yes  No | | | | | | | | | | | | | | | | | |