|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **T:\Program HUB\Program Services\Logos\Kavi Marketplace\Kavi logo-01.jpg**  **Employee Enrollment and Waiver Form** | | | | | | | | | | | | | | | | | |
| **EMPLOYER INFORMATION** ***(\*indicates required field)*** | | | | | | | | | | | | | | | | | |
| \*Employer Name | | | \*Effective Date     /     / | \*Date of Hire     /     / | | | **Event Description**  Open Enrollment  Hire/Rehire  Marriage/DP Birth/Adoption  COBRA Loss of Coverage  Court Order Name Change  New Address  Beneficiary  Termination  Non-COBRA Continuation | | | | | | | | | | |
| **\*Employee Type (Check all the apply) \*Hours Worked Per Week:**  Active COBRA  Non-COBRA Continuation Start date      **/**     **/**      End date      **/**     **/**       Hourly  Salary  Other \_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | |
| **EMPLOYEE INFORMATION** ***(\*indicates required field)*** | | | | | | | | | | | | | | | | | |
| \*First Name, Middle Initial, Last Name | | | | | Marital Status  Married/DP  Single Divorced  Widowed | | | | | \*Date of Birth  **/****/** | | \*Gender | | | | \*Social Security # | |
| M | | F | |
| Physical Home Address: | | | Mailing Address, if different: | | | Email Address: | | | | | \*Phone Number | | | | | Annual Salary | Employee Class |
| DEPENDENT INFORMATION (*\*indicates required field)* | | | | | | | | | | | | | | | | | |
| **\*Add or**  **Delete** | **\*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** | | **\*Social Security #** | | |
| Add  Delete | Spouse/Registered Domestic Partner (non-registered DP must submit an affidavit of DP) | | | | | | | **/**     **/** | | | | | 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, registered domestic partner, 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, registered domestic partner, birth, adoption, or date of assumption of total or partial legal obligation for support of a child in anticipation of adoption. | | | | | | | | | | | | | | | | | |
| **Plan Selections** | | | | | | | | | | | | | | | | | | |
| Medical and Prescription Drug (Rx) Plan Selection fromRegence BlueShield | | | **Employee**  **Employee and Spouse/Domestic Partner**  **Employee and Child(ren)**  **Family**  Please see your employer for plan details.  Platinum  Gold  Silver  Bronze  No Medical ***If no coverage selected, Please fill out waiver info below.***  **If your employer offers multiple products with the same Metal Level, please provide the following information:**  **Deductible:**       **Copay:**       **Coinsurance:**  If your employer is partnering with HealthEquity for your HSA bank account it will be created for you automatically:  Send my claims data to HealthEquity (optional) - I have read and agreed to the HSA authorization form  No, I don't want a HealthEquity HSA | | | | | | | | | | | | | | | |
| 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. **Dental Plan Name:** | | | | | | | | | | | | | | | |
| **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. **Vision Plan Name:** | | | | | | | | | | | | | | | |
| **Life/AD&D Plan** from LifeMap | | | $15,000 Basic Life/AD&D  $25,000 Basic Life/AD&D  Voluntary Life/AD&D $  Please see your employer for plan details. | | | | | | | | | | | | | | | |
| **Waiver of Coverage** | | | | | | | | | | | | | | | | | | |
| I decline all coverage for:  Myself  Spouse/Domestic Partner  Dependent Children  Myself and all dependents  I understand that by waiving coverage at this time, I will not be allowed to participate unless I qualify at a special enrollment period, if applicable, or at the next open enrollment period.  My current medical coverage is with: Carrier:       Policy Number:       Policy Type:       Policy holder:  (Please provide proof of coverage for employee and deps (as applicable), ie: medical ID card)  Date:      **/**     **/**      Employee Signature if waiving coverage: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | |
| Declining coverage due to existence of other coverage:  Spouse’s/Domestic Partner’s Employer Plan  Covered by Medicare  COBRA from Prior Employer  Tri-Care  Individual Plan  Medicaid  VA Eligibility  I (we) have no other coverage at this time  Other: | | | | | | | | | | | | | | | | | | |
| **Beneficiary Information** | | | | | | | | | | | | | | | | | | |
| **Beneficiary Information:**  **Must complete this section if enrolling in a Life/AD&D Plan** | | | 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. | | | | | | | | | | | | | | | | | | |

|  |  |  |
| --- | --- | --- |
| Signatures | | |
| **Employee and Employer Signature:**  I hereby apply for enrollment or change of enrollment as indicated on this application. I understand that Kavi Marketplace and the Carriers 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 Carriers 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 as otherwise permitted by law. It is a crime to knowingly provide false, incomplete, or misleading information to a Carrier 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 HIV/AIDS, Psychotherapy Notes, Alcohol/Drug and Genetic Testing. A separate authorization will be used for information related to these health conditions. 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. I authorize my employer to deduct from my earnings the amount, if any, for the coverage selected. | |
| Employee Signature and Date (Required for all Adds/Changes to enrollment)  Date:      **/**     **/**      Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Employee email address (for electronic notifications): | Employer Signature and Date  Date:      **/**     **/**  Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Carrier Contact Information** | |
| Regence BlueShield: 1800 9th Avenue, Seattle WA 98101; Customer Service – 888.367.2112  Delta Dental of Washington: 400 Fairview Avenue N, 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: PO Box 1271, M/S E-3A, Portland, OR 972017; Customer Service – 800.794.5390  **Please email applications to:**  [**kavi@tailorwell.com**](mailto:kavi@tailorwell.com) | |
|  | |

 ****  **** 