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| C:\Users\melanie_fisk\Desktop\Logos\NWBA Logo - Color.jpg**2018 Employee Enrollment Form****EMPLOYEE INFORMATION** ***(\*indicates required field)*** |
| **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 [ ]  Continuation of Coverage (COC) |
| **\*Employee Type (Check all the apply) \*Hours Worked Per Week**       [ ]  Active [ ] COBRA [ ]  State of Continuation Start date      **/**     **/**      End date      **/**     **/**      [ ]  Hourly [ ]  Salary [ ]  Other \_\_\_\_\_\_\_\_\_\_\_\_ |
| **EMPLOYEE INFORMATION** ***(\*indicates required field)*** |
| \*First Name, Middle Initial, Last Name      | Marital StatusMarried [ ]  Single [ ] Divorced [ ]  Widowed [ ]  | \*Date of Birth**/****/** | \*Gender | \*Social Security #      |
| [ ]  M | [ ]  F |
| \*Mailing Address, City, State, Zip Email Address                  | Cell/Home Phone      | Work Phone:      | 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. |
| **Plan Selections**  |
| Dental Plan Selection from Delta 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.  |
| **Basic Life AD&D** from USAble | [ ]  **Employee $20,000 Basic Life/AD&D** |
| **Waiver of Coverage** |
| I decline all coverage for: [ ]  Myself [ ]  Spouse/Domestic Partner [ ]  Dependent Children [ ]  Myself and all dependentsI understand that by waiving coverage at this time, I will not be allowed to participate unless I qualify at a special enrollment period or as a late enrollee, if applicable, or at the next open enrollment period.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:** | Primary Beneficiary Name and Relationship\*       | Primary Beneficiary Address      |
| Contingent Beneficiary Name and Relationship\*\*       | Contingent Beneficiary Address      |
| **Signatures** |
| **Employee and Employer Signature:**I hereby apply for enrollment or change of enrollment as indicated on this application I authorize the Trust and Carriers listed above to obtain, use and disclose my medical, claim or benefit records, including any individually identifiable health information contained in these records. I understand these records may contain information created by other persons or entities (including health care providers) as well as information regarding the use of drug, alcohol, HIV/AIDS, mental health (other than psychotherapy notes), sexually transmitted disease and reproductive health services. I authorize any health care provider, pharmacy benefit manager, other carrier/insurer or reinsurer, hospital, clinic or other medical facility, health care clearinghouse, and any of their affiliates, representatives or business associates, to disclose my information to the Trust and the Carriers. I understand that the purpose of the disclosure and use of my information is to allow the Trust and the Carriers to facilitate the appropriate management of treatment, services, payment and benefits. I further understand that the information disclosed will not be used for purposes of eligibility, enrollment, underwriting and premium risk rating. I understand this authorization is voluntary and I may refuse to sign the authorization. I understand I may revoke this authorization at any time by notifying the respective Carrier representative in writing, except to the extent that action has already been taken in reliance on this authorization. As required by HIPAA, UnitedHealthcare also requires that I acknowledge the following, which I do: I understand that information I authorize a person or entity to obtain and use may be re-disclosed and no longer protected by federal privacy regulations. This authorization, unless revoked earlier, expires 24 months after the date it is signed. I understand that I am completing a health application and that each response must be complete and accurate. I (we) request the indicated group medical coverage. I authorize any required premium contributions to be deducted from my earnings. I (we) have not given the agent or any other persons any required information not included on the application. I (we) understand that the Trust and the Carriers are not bound by any statements I (we) have made to any agent or to any other persons, if those statements are not written or printed on this application and any attachments.Please note that if you leave out information or make a misrepresentation on this form we may be allowed by law to take one or more of the following actions: terminate or non-renew your coverage or change your premium retroactively to the date your policy became effective.Please maintain a copy of this authorization for your records. 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. 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)Date:      **/**     **/**      Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Employee email address (for electronic notifications):       | Spouse/Domestic Partner (if applying for coverage) Employer Signature and DateDate:      **/**     **/**      Date:      **/**     **/**     Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Carrier Contact Information** |
| Delta Dental of Washington: 400 Fairview Ave. N., Seattle, WA 98109; Customer Service - 800.554.1907VSP, Vision Care Inc.: 3333 Quality Drive Rancho Cordova, CA 95670; Customer Service - 800.877.7195USAble Life: 320 W Capitol Ste 700 Little Rock, AR 72201 Customer Service – 877.357.4322 **Please send applications to: Business Solutions, Inc. NWBA Admin. PO Box 6, Mukilteo, WA 98275 Email:nwba@bsitpa.com** |

**Waiver of Co****verage **  ****