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| **C:\Users\theresa_obrien\AppData\Local\Temp\wz4b1c\WAHIT_Logo_Blue_Transp1.gif**  **Employee Enrollment and Change Form July 2017-June 2018 Plan Year** | | | | | | | | | | | | |
| Employer Name | | Effective Date     /     / | Date of Hire     /     / | | | **Event Description :** Event Date:      /     /  Open Enrollment  Hire/Rehire  Birth/Adoption  COBRA  Marriage/Domestic Partner Loss of Coverage  Court Order  Name Change  New Address  Beneficiary  Other | | | | | |
| **EMPLOYEE INFORMATION** ***(\*indicates required field)*** | | | | | | | | | | | |
| \*First Name, Middle Initial, Last Name | | | | | \*Date of Birth       /     / | | | \*Gender | | | \*Social Security # |
| M | F | |
| \*Mailing Address: City, State, Zip | | | | \*Phone Number | | | | \*Status  Single  Married | | | Employee Class |
| **Prior Coverage?**  **Yes**  **No (*If yes please reference page 2)*** | | | | | | | | | | | |
| 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** | | | **\*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 | | |  | | |
| **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) 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. | | | | | | | | | | | | |

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| PLAN SELECTIONS | *(spouse references also includes registered domestic partners)* | | |
| Medical and Prescription Drug (Rx) Plan Selection underwritten by Premera Blue Cross | **Employee only (EE)**  **EE + Spouse**  **EE + Children**  **EE + Spouse + Children**  Please see your employer for plan details.  ***If no coverage selected, attach waiver form.*** | | |
| Dental Plan Selection underwritten by Premera Blue Cross | **Employee only (EE)**  **EE + Spouse**  **EE + Children**  **EE + Spouse + Children**  Please see your employer for plan details. | | |
| **Vision Plan** underwritten by VSP Vision Care Inc. | Enrollment will match Medical and/or Dental election. | | |
| **Life and AD&D** underwritten by USAble Life  Please see your employer for plan details. | Enrollment is automatic when offered by the employer. Supplemental coverage requires a separate application. Amounts over the Guaranteed Issue will be subject  to health underwriting. **Employee Salary (for Salary based life plans):** | | |
| **Prior Medical Coverage** | | | |
| Prior Medical Carrier and Policy# | List all participants enrolled in prior medical plan: | | Duration of coverage:  Effective Date:      /     /  Termination Date:      /     / |
| **Beneficiary Information:** | 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. | | | |

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| **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:  Date:  Employee email address (for electronic notifications): | | Employer Signature:  Date: |
| Endorsed Carrier Contact Information | |
| Premera Blue Cross: 7001 220th Street S.W., Mountlake Terrace, WA 98043; Customer Service - 800.722.1471  VSP Vision Care Inc.: 3333 Quality Drive Rancho Cordova, CA 95670: Customer Service - 800.877.7195  USAble Life : 320 W Capitol Ste 700 Little Rock, AR 72201 Customer Service- 800.370.5856  ComPsych Employee Assistance Program : 455 N Cityfront Plaza Dr, Chicago, IL 60611; Customer Service - 877.357.4322 | |
| **For Employer Use Only**  **Medical underwritten by Premera Blue Cross: Standard Plans:**  Wellness 1  Wellness 2  HSA 2000  HSA 3000  Choice 1  Choice 2  Choice 3  Choice 4  Solutions 500  Solutions 750  Solutions 1000  Solutions 1500  Secure 500  Secure 750  Secure 1000  Secure 1500  Secure 2000  **Medical underwritten by Premera Blue Cross: Good Faith Plans:**  GF Choice 1  GF Choice 2  GF Choice 3A  GF Choice 3B  GF Choice 4  GF Solutions 500  GF Solutions 750  GF Solutions 1000  GF Solutions 1500  GF Solutions 2000  GF Secure 1000  **Dental underwritten by Premera Blue Cross:**  Dental Premier  Dental Select  Dental Plus   Dental Base  Dental PPO  **Vision underwritten by VSP Vision Care, Inc.:**  Base Vision  Vision Plus  **CompPsych Employee Assistance Plan:**  **USAble Life:**  Dependent Life  SupplementalLife and AD&D | |