Washington Business, Association and Chambers of Commerce Trust Employee Enrollment Form 2008

Group Number:

Employer Name	Effective Date Hire Date Hours worked per week	Salary **Class 1** ☐ **Class 2** ☐	Reason For Enrollment ☐ Hire/Rehire ☐ Loss of Coverage ☐ Birth/Adoption ☐ Open Enrollment ☐ Change Date of Marriage: ________ ☐ COBRA/Extension Termination Date: ______ Cobra Reason:

EMPLOYEE INFORMATION PLEASE PRINT CLEARLY

Last Name, First Name, Middle Initial	Employee's Birth Date	Gender: ☐ M ☐ F Marital Status : ☐ M ☐ S	Social Security #
Mailing Address, City, State, Zip, Phone			

PLAN SELECTIONS If no coverage selected, please attach waiver form. Medical Plans underwritten by Regence BlueShield

Medical and Dental underwritten by Regence BlueShield: PPO 1 ☐ PPO 2 ☐ PPO 4 ☐ PPO 5 ☐ HSA ☐

FourFront Plans - $200 Deductible ☐ $500 Deductible ☐ $750 Deductible ☐ $1,000 Deductible ☐ Selections Plans - 100/70/15 ☐ 80/50/15 ☐

Regence Dental - High Option ☐ Low Option ☐ Managed Care (Willamette Dental Group) ☐ **Legal Plan underwritten by Caldwell Legal** ☐

Voluntary Personal Accident underwritten by AIG: Individual ☐ Family ☐ **Vision underwritten by VSP**: 12/12/24 ☐ 24/24/24 ☐

DEPENDENT INFORMATION

Add or Delete (Check One) Add	Delete	Name of Dependent (If dependent has different mailing address, please attach) Last, First	Birth Date (Over Age 25 requires certificate)	Gender (Check One)	Social Security #	Primary Care Physician (PCP) Required For Selections Plans Only Employee PCP:	Primary Care Physician (PCP) ID # Employee PCP ID#
☐	☐	Spouse/DP		M ☐ F ☐			
☐	☐	Child		M ☐ F ☐			
☐	☐	Child		M ☐ F ☐			
☐	☐	Child		M ☐ F ☐			
☐	☐	Child		M ☐ F ☐			

PRIOR COVERAGE

Do you or any of your dependents applying for coverage have coverage now, or within the past 3 months, with any health care plan? ☐ Yes ☐ No (If yes, please complete the following for waiting period credits)

Other Insurance:	Policy ID#:	Date Coverage Began:	Date Coverage Ended:
Policy Holder's Name:	Phone #: ( )	Date of Birth:	Social Security #:
Persons Covered:			
If you have Medicare, what was the start date for:	Part A:	Part B:	Medicare HIC# with Alpha Suffix:

If the dependent child(ren) being added is/are covered under another plan and the natural parents are divorced or separated, Washington Sate regulations require that we ask the following:
Name of parent with custody (if parents have dual custody, please indicate): ______________________________
If divorced, did the court establish financial responsibility for the child(ren)'s healthcare? ☐ Yes ☐ No
If yes, please specify the name and address of the parent responsibility: ______________________________

"I hereby apply for enrollment or change of enrollment as indicated on this application. I have provided these answers as part of the application procedure required by the insurer(s) to enroll in coverage and I certify that all information completed on this form is true, correct, and complete. I understand that the insurer(s) will rely on each answer in making coverage and rating determinations. For the protection of all of our members, fraud or misrepresentation of material fact by me for the purposes of defrauding the insurer(s) may result in the insurer(s) taking any action allowed by law or Contract, including termination or rescission of coverage, denial of benefits, and/or pursuit of criminal charges and penalties."

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. *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 Regence BlueShield Web site at www.wa.regence.com or by phone at 1-800-458-3523 or 1-206-464-3663.

LIFE INSURANCE plans underwritten by Regence Life and Health - PO Box 1271, Portland, OR 97207	SIGNATURE
Primary Beneficiary ____________ Relationship ________	Employee Signature ____________ Date ________
Secondary Beneficiary ____________ Relationship ________	Employer Signature ____________ Date ________
Amount $____________	
Dependent Life ☐ Yes ☐ No Short Term Disability ☐ Yes ☐ No Long Term Disability ☐ Yes ☐ No	

For individuals who are eligible for enrollment in a group health plan: If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or 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 group health plan coverage, the employer stops contributing toward you or your dependents' other coverage.) However, you must request enrollment within 31 Days after your 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 must request enrollment within 31 days after the marriage, or within 60 days of birth, adoption, or placement for adoption, or date of assumption of total or partial legal obligation for support of a child in anticipation of adoption.