



Employee Enrollment Application, Cancellation, and Waiver

Effective Date of Enrollment, Termination or Change:		Employer Name:		Medical: ☐ Add ☐ Delete Dental: ☐ Add ☐ Delete		
Check One	☐ Open Enrollment ☐ Waiving	☐ New Enrollee ☐ COBRA	☐ Name Change ☐ Address Change	☐ Add Dependents ☐ Delete Dependents	Med Plan: Class:	
Personal Information: (Please Print Clearly)						
Employee Name:	Last:			SSN:		
	First: M.I:			Date of Birth:	/ /	
Mailing Address:				Hire Date:	/ /	
City:		State:		Zip Code:		
Phone:		Marital Status:		Date of Marriage or Domestic Partnership:		
				Gender: ☐ Male ☐ Female		
Election						
Name of Enrolling Dependent(s):	Birth Date:	Relationship to Employee:	Sex:	SSN:	Medical	Dental
1)		☐ Spouse ☐ Child ☐ Domestic Partner	☐ Male ☐ Female		☐ Add ☐ Delete	☐ Add ☐ Delete
2)		☐ Child	☐ Male ☐ Female		☐ Add ☐ Delete	☐ Add ☐ Delete
3)		☐ Child	☐ Male ☐ Female		☐ Add ☐ Delete	☐ Add ☐ Delete
4)		☐ Child	☐ Male ☐ Female		☐ Add ☐ Delete	☐ Add ☐ Delete
5)		☐ Child	☐ Male ☐ Female		☐ Add ☐ Delete	☐ Add ☐ Delete
6)		☐ Child	☐ Male ☐ Female		☐ Add ☐ Delete	☐ Add ☐ Delete
Beneficiary for Basic Life / AD&D Insurance Benefit						
Name:			Relationship:			
Address:						
Current Coverage, Prior Coverage and Coordination of Benefits: If you or any dependent currently has or has had other group medical coverage (including Medicare) within the last three calendar months, please complete below.						
Name of Family Member	Other Employer (or Medicare)	Date Coverage Began	Date Coverage Ended	Name of Insurance Carrier	Group Number	



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By signing below, I acknowledge that I have read, understand, and agree to the Terms & Conditions on all pages of this application.

Employee Signature

Date

Terms & Conditions

Application Agreement

I hereby apply for coverage under the contract between the issuer and my employer or group, and I agree with the terms of the contract. I also apply for the same coverage for my spouse or domestic partner and/or my children listed on this application. I attest that my listed dependents and I meet all the eligibility criteria set forth in the outline of benefits and/or the contract.

I agree to pay in advance the appropriate rates for myself and listed dependents and authorize rate increases as the company deems necessary.

Anti-Fraud Statement

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 have provided these answers as part of the application procedure required by the issuer to enroll in coverage and I attest that all information completed on this application is true, correct, and complete. I understand that the issuer will rely on each answer in making coverage and rating determinations.

Release of Information

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 application) 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.

Medical Coverage Underwritten by

Premera Blue Cross; 7001 220th St SW; Mountlake Terrace, WA 98043

Premera Blue Cross HMO; 7001 220th St SW; Mountlake Terrace, WA 98043

Dental Coverage Underwritten by

Delta Dental of Washington; 400 Fairview Avenue North, Suite 800, Seattle, WA 98109

Vision Coverage Underwritten by

VSP Vision Care, Inc.(HCSC); 3333 Quality Drive; Rancho Cordova, CA 95670

Life/AD&D Coverage Underwritten by:

USABLE Life; P.O. Box 1650 Little Rock, AR 72223

Employee Assistance Program Coverage Underwritten by:

First Choice Health Network, Inc.; 600 University Street, Ste 1400; Seattle, WA 98101

Administered by *Vimly Benefit Solutions*

Physical address:

12121 Harbour Reach Drive, Suite 105

Mukilteo, WA 98275

Phone:

(425) 771-7359

Mailing address:

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