

Employee Enrollment/Change Form



EMPLOYER NAME _____ **EMPLOYER NUMBER** _____

ENROLLMENT Requested Effective Date: ____ / 01 / 200____ Employee Date of Hire: ____ / ____ / ____ Please check appropriate box below: <input type="checkbox"/> New employee <input type="checkbox"/> New employee & dependent(s) <input type="checkbox"/> New dependent(s) (Please specify qualifying event at right)	QUALIFYING EVENT FOR SPECIAL ENROLLMENT Please check box below: <input type="checkbox"/> Marriage/Domestic Partnership (Affidavit Required) Date of marriage/partnership ____ / ____ / ____ <input type="checkbox"/> Involuntary Loss of Coverage <input type="checkbox"/> Adoption/Legal Guardian (Legal documentation required) <input type="checkbox"/> Birth <input type="checkbox"/> Divorce <input type="checkbox"/> Death	CHANGE Please check box below: <input type="checkbox"/> Name Change <input type="checkbox"/> Address Change <input type="checkbox"/> Beneficiary Change <input type="checkbox"/> Delete Dependent(s) Effective date ____ / ____ / ____ <input type="checkbox"/> COBRA / Continuation Coverage Start date ____ / 01 / 200____	DENTAL PLAN SELECTION If your Employer is enrolling 5 or more Employees and is choosing a Dental product you're responsible for selecting the carrier of your choice. If you have any questions your employer will gladly assist you during the enrollment process <input type="checkbox"/> Washington Dental Service <input type="checkbox"/> Willamette Dental
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EMPLOYEE INFORMATION

Last Name	First Name	M.I.	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth / /
Mailing Address		Apt #	City, State, Zip	
Social Security Number - -	Home Phone ()	Work Phone ()	Email	
Are you covered by workers' compensation: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Exempt			Current Job Title	
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced		<input type="checkbox"/> Domestic Partnership (Affidavit Required)		
Prior Coverage <input type="checkbox"/> YES <input type="checkbox"/> NO	Insurance Carrier:	Start date of prior coverage : ____ / ____ / ____	End date of prior coverage: ____ / ____ / ____	

DEPENDENT INFORMATION (Please check the add or delete box for each enrollee)

Add <input type="checkbox"/>	Delete <input type="checkbox"/>	Relationship to employee	Last Name	First Name	Social Security Number - -	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth / /
			Previous coverage- HIPAA: Prior carrier:	Start date of prior coverage: / /	Prior coverage ended: / /		
Add <input type="checkbox"/>	Delete <input type="checkbox"/>	Relationship to employee	Last Name	First Name	Social Security Number - -	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth / /
			Previous coverage- HIPAA: Prior carrier:	Start date of prior coverage: / /	Prior coverage ended: / /		
Add <input type="checkbox"/>	Delete <input type="checkbox"/>	Relationship to employee	Last Name	First Name	Social Security Number - -	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth / /
			Previous coverage- HIPAA: Prior carrier:	Start date of prior coverage: / /	Prior coverage ended: / /		
Add <input type="checkbox"/>	Delete <input type="checkbox"/>	Relationship to employee	Last Name	First Name	Social Security Number - -	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth / /
			Previous coverage- HIPAA: Prior carrier:	Start date of prior coverage: / /	Prior coverage ended: / /		

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DEPENDENT INFORMATION CONTINUED (Please check the add or delete box for each enrollee)

Add <input type="checkbox"/>	Delete <input type="checkbox"/>	Relationship to employee	Last Name			First Name			
			Social Security Number - -			Gender <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth / /		
			Previous coverage- HIPAA: Prior carrier:			Start date of prior coverage: / /		Prior coverage ended: / /	
Add <input type="checkbox"/>	Delete <input type="checkbox"/>	Relationship to employee	Last Name			First Name			
			Social Security Number - -			Gender <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth / /		
			Previous coverage- HIPAA: Prior carrier:			Start date of prior coverage: / /		Prior coverage ended: / /	
Add <input type="checkbox"/>	Delete <input type="checkbox"/>	Relationship to employee	Last Name			First Name			
			Social Security Number - -			Gender <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth / /		
			Previous coverage- HIPAA: Prior carrier:			Start date of prior coverage: / /		Prior coverage ended: / /	
Add <input type="checkbox"/>	Delete <input type="checkbox"/>	Relationship to employee	Last Name			First Name			
			Social Security Number - -			Gender <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth / /		
			Previous coverage- HIPAA: Prior carrier:			Start date of prior coverage: / /		Prior coverage ended: / /	

BENEFICIARY FOR EMPLOYEE'S LIFE BENEFIT

Beneficiary Name	Beneficiary Address	Relationship to employee
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APPLICANT / HIPAA ACKNOWLEDGEMENT

I am an active full-time employee regularly working at least 20 hours per week. All information given by me on this form is true and complete. My signature below attests that the prior coverage data provided above is complete and accurate to the best of my knowledge, and can be documented upon request with evidence of coverage from my, and my dependents prior plan(s). I acknowledge the authorization for the Association of Washington Business to obtain information from third parties regarding any matters that may bear on this application.

I understand that AWB HealthChoice and the insurance carriers may collect, use and disclose protected health information about each individual enrolled under this application in order to carry out its routine business functions, which include, but are not limited to, determining eligibility for benefits, paying claims, coordinating benefits with other insurance carriers or payers, underwriting and conducting case management, care management and quality reviews. AWB HealthChoice and the insurance carriers may also disclose protected health information to state and federal agencies or other third parties as required by law.

FRAUD WARNING 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. Any person who knowingly and with intent to defraud a health care service contractor or any other person files a request for benefit coverage or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent act which may result in the denial of health care coverage or insurance coverage.

This application must be signed

Please return this form to your employer

Applicant Signature _____

Date _____

Underwritten by:

LifeWise Assurance Company
7007 - 220th SW
Mountlake Terrace, WA 98043

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

Vision Service Plan (VSP)
600 University St Ste 2004
Seattle, WA 98101

Washington Dental Service
9706 4th Ave. NE
Seattle, WA 98115

Willamette Dental of Washington, Inc.
181 S 333rd St. Suite C-100
Federal Way, WA 98003