Benefit Enrollment Form 2024 – 2025

Instructions: **This form provides you with the different options you may elect. Indicate your benefit choice by checking the box next to the desired benefit options.** *Complete this form and return it to Human Resources.*

To be completed by EMPLOYER			
Date of Hire/Rehire:		Job Title:	
Location:			
Effective Date of Change/Coverage		Reason	
Class		Employee #	
☐ Open Enrollment ☐ New Hire ☐ Cancel ☐ Change ☐ Reinstate			

To be completed by EMPLOYEE			
First Name:		Phone #:	
Last Name:		Date of Birth:	(mm/dd/yyyy)
Home Address:		Social Security #:	
		Gender:	☐ Male ☐ Female
City:		Marital Status:	☐ Single ☐ Married ☐ Domestic Partner
State:			
Zip:			
Email Address:			

Medical, Dental, Vision & Life / AD&D *(check which plans you want to enroll in)*					
Medical Plan	☐ I Elect Coverage	☐ I Decline Coverage	Voluntary Dental Plan	☐ I Elect Coverage	☐ I Decline Coverage
Select if you plan on enrolling	☐ Access PPO		Voluntary Vision Plan	☐ I Elect Coverage	☐ I Decline Coverage
	☐ Virtual Plus		Life / AD&D	☐ I Elect Coverage	☐ I Decline Coverage

Dependent Elections & Information
(check which plans you want to enroll your dependents in, use additional form for more dependents)

Add	Drop	First Name	Last Name	Relationship to Employee	Social Security #	Date of Birth (mm/dd/yyyy)	Gender
☐ Medical ☐ Dental ☐ Vision	☐ Medical ☐ Dental ☐ Vision						☐ Male ☐ Female
☐ Medical ☐ Dental ☐ Vision	☐ Medical ☐ Dental ☐ Vision						☐ Male ☐ Female
☐ Medical ☐ Dental ☐ Vision	☐ Medical ☐ Dental ☐ Vision						☐ Male ☐ Female
☐ Medical ☐ Dental ☐ Vision	☐ Medical ☐ Dental ☐ Vision						☐ Male ☐ Female

IMPORTANT: All employees must read and sign the back side of this form for coverage to take effect.

Life and AD&D Insurance Beneficiary					
Beneficiaries	**Name**	**Relationship**	**Benefit %**	**Social Security #**	**Address**
Primary					
Primary					
Secondary					
Secondary					

I understand that March 2024 is the open enrollment period, for an April 1, 2024 effective date, and this is my opportunity to make any changes to my participation in the Employee Benefit Plan. I understand that I will not be eligible to make changes to my participation in the Employee Benefit Plan until April 1, 2025 (unless I or my eligible dependents qualify for a family status change or have lost coverage elsewhere) and that if coverage is waived, future enrollment will be subject to limitations.

I understand eligible dependents include: my legally married spouse, domestic partner (Washington State Registered Domestic Partners are treated the same as a spouse) and my and/or my spouse/DP's dependent children up to age 26 (regardless of marital status, student status, or eligibility for coverage under another plan). I acknowledge that any persons on this application for coverage are my dependents, as described under the Plan. I agree that falsification of any statement in my application may bar the right to coverage under the Plan. I acknowledge that the information I have provided is true and complete. I further understand that it is my obligation to notify my employer when my spouse, domestic partner or child no longer meets the eligibility requirements described under the Plan. Once a person does not meet the Plan definition of a dependent, they are no longer eligible for benefits. I understand Employees may not pay for domestic partner health insurance premiums with pre-tax dollars unless the partner qualifies as a dependent. In addition, amounts paid by the company for domestic partner coverage are treated as taxable income to the employee.

I have provided these answers as part of the application procedure required by issuers to enroll in coverage and I acknowledge that all information completed on this form is true, correct, and complete. 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. All benefits will be governed by the terms of the benefit contracts. My signature below indicates that I have read and understand this enrollment form and descriptive materials provided.

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 carrier's Privacy Policy. A copy is available from each carrier web site or by phone.

For residents of Tennessee and Washington: 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.

____________________________________	________________________
Employee Signature	**Date**

Medical benefits underwritten by Kaiser Foundation Health Plan of Washington Options, Inc.
Vision benefits underwritten by Principal Financial.
Dental benefits underwritten by Principal Financial.
Life benefits underwritten by Principal Financial.

Kaiser Foundation Health Plan of Washington Options, Inc.
1300 SW 27th Street
Renton, WA 98057

Access PPO: 8519300

Kaiser Foundation Health Plan of Washington
1300 SW 27th Street
Renton, WA 98057

Virtual Plus: 2198100

Principal Financial
520 Pike Street #1400
Seattle, WA 98101

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