CA/NV – HOME EMPLOYEES

Aegis Living

Benefit Enrollment Form 2020 - 2021

☐ New ☐ Cancel ☐ Change ☐ Reinstate

Effective Date of Change/Coverage _____
Reason _____
Class _____
Employee # _____

Instructions: this form provides you with the different options you may elect.
Complete and return this form to your Business Office Manager (Kim Stabler for Home Office employees) within 30 days of your eligibility date.

Indicate your benefit choice by checking the box next to the desired benefit options.

Medical benefits underwritten by Premera Blue Cross.
Dental benefits underwritten by Delta Dental of Washington.
Vision benefits underwritten by Vision Service Plan.

Premera Blue Cross
7001 220th St SW, MS 323 Building 3
Mountlake Terrace, WA 98043
Group ID # 1007261

Delta Dental of Washington
9706 Fourth Avenue NE
Seattle, WA 98115
Group ID # 9109

Vision Service Plan
3333 Quality Dr
Rancho Cordova, CA 95670
Group ID # 12233736

To be completed by EMPLOYER			
Date of Hire/Rehire:		Job Title:	
Location:		Annual Salary:	

To be completed by EMPLOYEE (due to character limits on Premera ID cards, your full name may not be presented)			
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:			

Medical Plan Election *(please select one of the medical options below. If you decline coverage select the reason below.)*		
Core Medical Plan – Heritage *Plus 1* network	☐ I Elect Coverage	☐ I Decline Coverage* *Reason for declining medical coverage: ☐ I am covered by my spouse's medical plan ☐ I am covered by my parent's medical plan ☐ I am covered by Medicare (generally for age 65+) ☐ I am covered by Medicaid ☐ I have individual coverage ☐ I choose not to have medical coverage ☐ Other: _____
Buy-Up Medical Plan – Heritage *Plus 1* network	☐ I Elect Coverage	

Dental and Vision Plan Elections *(please select one of the dental and vision options below)*		
Dental Plan	☐ I Elect Coverage	☐ I Decline Coverage
Vision Plan	☐ I Elect Coverage	☐ I Decline Coverage

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

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			☐ Spouse ☐ Dom Ptnr			☐ Male ☐ Female
☐ Medical ☐ Dental ☐ Vision	☐ Medical ☐ Dental ☐ Vision			☐ Son ☐ Daughter			☐ Male ☐ Female
☐ Medical ☐ Dental ☐ Vision	☐ Medical ☐ Dental ☐ Vision			☐ Son ☐ Daughter			☐ Male ☐ Female
☐ Medical ☐ Dental ☐ Vision	☐ Medical ☐ Dental ☐ Vision			☐ Son ☐ Daughter			☐ Male ☐ Female

Life Insurance Beneficiary *(For Basic Life/AD&D underwritten by The Hartford, Group #678078)*					
Beneficiaries	Name	Relationship	Benefit %	Social Security #	Address
Primary					
Primary					
Secondary					
Secondary					

I understand that I will not be eligible to make changes to my participation in the Employee Benefit Plan until April 1, 2021 (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 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 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 and I must notify the plan immediately.

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.

_____ _____

Employee Signature Date