

WA – HOME EMPLOYEES

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
<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision			<input type="checkbox"/> Spouse <input type="checkbox"/> Dom Ptnr			<input type="checkbox"/> Male <input type="checkbox"/> Female
<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision			<input type="checkbox"/> Son <input type="checkbox"/> Daughter			<input type="checkbox"/> Male <input type="checkbox"/> Female
<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision			<input type="checkbox"/> Son <input type="checkbox"/> Daughter			<input type="checkbox"/> Male <input type="checkbox"/> Female
<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision			<input type="checkbox"/> Son <input type="checkbox"/> Daughter			<input type="checkbox"/> Male <input type="checkbox"/> 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
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