



Benefit Enrollment Form 2020 - 2021

New Cancel Change Reinstate

Effective Date of Change/Coverage

	ReasonClass	
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.	Premera Blue Cross 7001 220th St SW, MS 323 Building 3 Mountlake Terrace, WA 98043	Group ID # 1007261
Indicate your benefit choice by checking the box next to the desired benefit options.	Delta Dental of Washington 9706 Fourth Avenue NE Seattle, WA 98115	Group ID # 9109
Medical benefits underwritten by Premera Blue Cross. Dental benefits underwritten by Delta Dental of Washington. Vision benefits underwritten by Vision Service Plan.	Vision Service Plan 3333 Quality Dr Rancho Cordova, CA 95670	Group ID # 12233736
To be completed by EMDLOVED		

To be completed by LWI LOTER					
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:			Soc	cial Security #:		
			Gender:		🗌 Male 🔲 Female	
City:			Marital Status:			
State:					Single Married Domestic Partner	
Zip:						
Medical Plan Election	on (please select	one of the medical options below. If you de	cline	coverage select t	the reason below.)	
Core Medical Plan – Heritage <u>Prime</u> netw		I Elect Coverage		☐ I Decline Coverage*		
Core Medical Plan – Heritage <u>Plus 1</u> network		I Elect Coverage		🗆 I am cove	clining medical coverage: ered by my spouse's medical plan ered by my parent's medical plan	
Buy-Up Medical Plan – Heritage <u>Prime</u> network		I Elect Coverage		 □ I am covered by Medicare (generally for age 65 □ I am covered by Medicaid □ I have individual coverage 		
Buy-Up Medical Pla Heritage <u>Plus 1</u> netv		I Elect Coverage		□ I choose not to have medical coverage □ Other:		
Dental and Vision Plan Elections (please select one of the dental and vision options below)						
Dental Plan I Elect Coverage		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.

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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
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			□ Son □ Daughter			MaleFemale

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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