Group Number:

Washington Business, Association and Chambers of Commerce Trust
Employee Enrollment Form
2007

Employer Name	Effective Date Hire Date Hours worked per week	Salary Class 1 ☐ Class 2 ☐	Reason For Enrollment ☐ Hire/Rehire ☐ Loss of Coverage ☐ Birth/Adoption ☐ Open Enrollment ☐ Change Date of Marriage: ________ ☐ COBRA/Extension Termination Date: ________ Cobra Reason:

EMPLOYEE INFORMATION **PLEASE PRINT CLEARLY**

Last Name, First Name, Middle Initial	Employee Birth Date	Gender: ☐ M ☐ F Marital Status : ☐ M ☐ S	Social Security #

Mailing Address	City	State	Zip	Phone

PLAN SELECTIONS If no coverage selected, please attach waiver form. Medical Plans underwritten by Regence BlueShield

PPO 1 ☐ PPO 2 ☐ PPO 3 ☐ PPO 4 ☐ PPO 5 ☐ HSA ☐ Regence Dental Plans - High Option☐ Low Option☐ Managed Care (Willamette Dental Group) ☐
FourFront Plans - $200 ☐ $500 ☐ $750 ☐ $1,000 ☐ Vision Service Plans - 12/12/24 ☐ 24/24/24 ☐ Caldwell Legal Benefits ☐
Selections Plans - 100/70/15 ☐ 80/50/15 ☐ 70/50/20 ☐ Traditional 50/50 ☐ Voluntary Personal Accident - Individual ☐ Family ☐

DEPENDENT INFORMATION

Add or Delete (Check One) Add	Delete	Name of Dependent (If dependent has different mailing address, please attach) Last, First	Birth Date (Over Age 25 requires certificate)	Gender (Check One)	Social Security #	Primary Care Physician (PCP) Required For Selections Plans Only	Primary Care Physician (PCP) ID #
☐	☐	Spouse/DP		M ☐ F ☐			
☐	☐	Child		M ☐ F ☐			
☐	☐	Child		M ☐ F ☐			
☐	☐	Child		M ☐ F ☐			
☐	☐	Child		M ☐ F ☐			

PRIOR COVERAGE

Do you or any of your dependents applying for coverage have coverage now, or within the past 3 months, with any health care plan? ☐ **Yes** ☐ **No** (If yes, please complete the following for waiting period credits)

Other Insurance:	Policy ID#:	Date Coverage Began:	Date Coverage Ended:
Policy Holder's Name:	Phone #: ( )	Date of Birth:	Social Security #:
Persons Covered:			
If you have Medicare, what was the start date for:	Part A:	Part B:	Medicare HIC# with Alpha Suffix:

If the dependent child(ren) being added is/are covered under another plan and the natural parents are divorced or separated, Washington Sate regulations require that we ask the following:
Name of parent with custody (if parents have dual custody, please indicate): ________
If divorced, did the court establish financial responsibility for the child(ren)'s healthcare? ☐ Yes ☐ No
If yes, please specify the name and address of the parent responsibility: ________

LIFE INSURANCE plans underwritten by Regence Life and Health

Primary Beneficiary ________ Relationship ________
Secondary Beneficiary ________ Relationship ________
Amount $ ________

Dependent Life ☐ **Yes** ☐ **No** **Short Term Disability** ☐ **Yes** ☐ **No** **Long Term Disability** ☐ **Yes** ☐ **No**

SIGNATURE

I hereby verify that all of the information specified above is accurate and complete. I have also read and understand the Application Agreement and Release of information provided. By checking the appropriate box, I am enrolling under and have authorized the release of information to Regence BlueShield.

Employee Signature ________ Date ________

Employer Signature ________ Date ________

"I acknowledge and understand that my health plan may request or disclose
health information about me or my dependents (persons who are listed for
benefits coverage on the enrollment form) from time to time 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 Regence Consumer Privacy
Notice. A copy is available (web, phone request, etc.).

For individuals who are eligible for enrollment in a group health plan: If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if, in the case of group health plan coverage, the employer stops contributing toward you or your dependents' other coverage.) However, you must request enrollment within 31 Days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). In addition, if you gain a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 31 days after the marriage, or within 60 days of birth, adoption, or placement for adoption, or date of assumption of total or partial legal obligation for support of a child in anticipation of adoption.