Employee: Please complete all sections (front & back) in black ink

MBA Health Insurance Trust Employee / Subscriber Application

Select Plan

Health plans underwritten by Regence BlueShield: ❑ Enhanced Plan _____ ❑ Market Plan _____ ❑ Market "Plus" Plan _____ ❑ Foundation Plan _____ ❑ Foundation "Plus" Plan _____ ❑ HSA Plan _____

Health plans underwritten by Group Health Options, Inc: ❑ Alliant Plus Plan _____ ❑ Alliant Plus HSA Plan _____

EMPLOYEE SECTION:

Employee Legal Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone #: _____

Marital Status: ❑ Married ❑ Single **Date of Marriage:** _____

Has Regence BlueShield or Group Health Options, Inc assigned an alternate Identification number to you previously?

❑ Yes ❑ No If yes, please provide if available _____

Please Note: List all eligible dependents to be insured, continue on another form if more space needed.

A Reason Must be Checked for Application:

Add Employee
- ❑ New group
- ❑ New employee
- ❑ Open enrollment
- ❑ Loss of eligibility on another coverage

Add Dependent
- ❑ Birth ❑ Marriage ❑ Adoption
- ❑ Domestic Partner
- ❑ COBRA coverage exhausted
- ❑ Open enrollment
- ❑ Loss of eligibility on another coverage (must attach proper documentation)

- ❑ Change of Life Beneficiary
- ❑ Change of Address
- ❑ Name Change
- ❑ Change Medical Plan*

*** Medical Plan election changes are allowed only during the Open Enrollment Period each year.**

Relationship	Last Name	First Name	M.I.	**Social Security Number** or Individual tax payer ID number (ITIN)	**Birth Date** (mm/dd/yyyy)	**Gender** M/F
Employee				- -	/ /	
Spouse/Domestic Partner				- -	/ /	
Child				- -	/ /	
Child				- -	/ /	
Child				- -	/ /	

BASIC LIFE INSURANCE BENEFICIARY: This section must be completed for all new employee enrollments. If no beneficiary is designated, benefits will be paid under the terms of the group insurance contract.

Beneficiary's Name: _____ Relationship: _____ Beneficiary's Birthdate: _____ Provided by: LifeMap Assurance Company

Beneficiary's Address: _____ City/State/Zip: _____ Phone Number: _____ 100 SW Market Street, Portland, OR 97207

EMPLOYEE RELEASE AND AUTHORIZATION: I hereby verify that all of the information specified above is accurate and complete. By signing below, I have authorized the release of information, for myself and my dependents listed on this application, to Regence BlueShield or Group Health Options, Inc.

EMPLOYEE'S SIGNATURE: _____ **DATE**: _____

Contractual Effective Date and Eligibility: Applications for new employees must be received by the MBA Trust within 15 days of the Contractual Effective Date. The Contractual Effective Date is based on the employee's date of hire and your company's established probationary period. Applications received after the Contractual Effective Date may delay an employee's eligibility date to the next MBA Trust Open Enrollment period. New MBA application forms are required to add dependents, including newborns and/or a new spouse (see Plan Booklets for details). Applicants should carefully review the program's "Waiting Periods Limitations". Review the plan benefit booklets or contact your company's administrator (or the MBA Trust) to address any questions on these important provisions.

EMPLOYER SECTION:

The Employer section must be completed & signed by the Group's Contact Person as listed on the Employer Participation Agreement. If not fully completed, this form will be returned unprocessed.

Group Name: _____ Group Number: _____ Division Number: _____ Group Phone Number: _____ Intended Effective Date: _____/_____/_____

Employee Class (i.e. Hourly or Salaried): _____ Date of Hire: _____/____/____ Date of Rehire: _____/____/__ Date Changed from Part-time to Full-time: _____/____/__ Average Hours Worked Per Week: _____

SIGNATURE OF GROUP'S PRIMARY CONTACT PERSON: _____ **Date**: _____

If any dependent child(ren) being added is/are covered under another plan and the natural parents are divorced or separated, Washington State regulations require that we ask the following:

Name of parent with custody (if parents have dual custody, indicate): _____

If divorced, did the court establish financial responsibility for the child(ren)'s health care? ❑ Yes ❑ No (Please provide a copy of the divorce decree maintenance agreement outlining coverage specifications.)

If YES, please specify the name and address of the parent with responsibility: _____

Do you or any of your dependents applying for coverage have coverage (now, or within the past 6 months) with any health care plan? ❑ Yes ❑ No. Will coverage remain in effect? ❑ Yes ❑ No
IMPORTANT: If you or any of your dependents applying for coverage have coverage (now, or within the past 6 months) with any health care plan, you MUST complete the information below.

Crediting of time covered under a previous insurance plan (such as other group or individual coverage) towards a new plan's pre-existing condition waiting period (i.e. Portability of coverage) is available under the MBA Trust in accordance with State and Federal insurance regulations. Completing the information below will allow Regence BlueShield or Group Health Options, Inc to credit any applicable waiting periods for preexisting conditions and process claims quickly and accurately. All MBA plans include a 3-month waiting period for Pre-Existing Conditions. In order for our carriers to determine if you or any of your dependents are eligible for portability of coverage in accordance with State and Federal laws, please provide a "Certificate of Creditable Coverage" from your prior health insurance carrier; or, complete the "Prior Coverage Information" section below. To obtain more information on waiting periods, pre-existing conditions and transplant related benefits, please contact your group administrator or benefits department.

PRIOR INSURANCE WITHIN THE PAST 6 MONTHS AND/OR CURRENT OTHER INSURANCE COVERAGE:

Prior or Other Insurance Company Name:_____ Prior or Other Insurance Company Phone #:_____

Prior or Other Insurance Company Full Address: _____

Policyholder's Name:_____ Policyholder's Birth Date:_____/_____/_____ (mm/dd/yyyy) Policy Holder's Member ID# or Social Security #:_____

Group Name & Policy #: _____ Effective Date of Coverage: _____/_____/_____ Intended Termination Date of Coverage: _____/_____/_____ Reason for Termination:_____

Persons covered by prior insurance (list names and date of birth for each): _____

Type of Coverage (please circle): Medical Pharmacy Dental Vision Medicare **Type of Policy** (please circle): Group Individual Medicaid Medicare Part A Medicare Part B Other:_____

If employee or dependents have Medicare, what was the begin date for Part A:_____ Part B:_____ Medicare HIC# with Alpha Suffix:_____

Name of Person covered by Medicare _____ Reason: ❑ Disability ❑ Over Age 65 ❑ End Stage Renal Disease

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Application Agreement: I have provided these answers as part of the application procedure required by Regence BlueShield or Group Health Options, Inc to enroll in coverage and I certify that all information completed on this form is true, correct and complete. I understand that Regence BlueShield or Group Health Options, Inc will rely on each answer in making coverage and rating determinations. 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.

HIPAA Special Enrollment Provisions: If I have waived enrollment and completed a "Waiver of Insurance Form" for myself or any of my dependents (including my spouse) because of other health insurance or group health plan coverage, I may in the future be able to enroll the waived individuals in this plan, provided I request enrollment within 30 days after the other coverage of the individual(s) ends due to loss of eligibility or an employer's ceasing to contribute toward that other coverage. In addition, if I have a new dependent as a result of marriage, birth, adoption, or placement for adoption, I may be able to enroll myself and my dependents, provided that I request enrollment within 30 days after the marriage, or within 60 days after the birth, adoption, or placement.

Release of Information: 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 Notice of Privacy Practices. A copy is available from our Website at www.epkbenefits.com or by phone at (800) 545-7011 or (425) 641-7762.

Coverage underwritten by: Regence BlueShield
1800 Ninth Avenue -- Seattle, WA 98101
Group Health Options, Inc
320 Westlake Ave -- Seattle, WA 98109

Mail or Fax to:
EPK & Associates, Inc. - 15375 SE 30th Place #380 - Bellevue, WA 98007
Phone: 800-545-7011 - Fax 425-641-8114 - Email: admin@epkbenefits.com