™ Washington Alliance for Health Insurance Trust

NWtech
Northwest Technologies Employee Benefits Program

EMPLOYEE MEDICAL/DENTAL ENROLLMENT APPLICATION

W/_____

★ Indicates mandatory field

★ ENROLLMENT AND/OR CHANGE INFORMATION (Check One):	★ Effective Date of Enrollment or Change ➔	/ 01 /

Reason for Enrollment:
- ❑ Open Enrollment
- ❑ New Hire or new to Eligible Class
- ❑ COBRA / Continuation - start date ____/____/____
- ❑ Special Enrollment (See *Specify Enrollment Qualifying Event* section to the right)

Reason for Change:
- ❑ Name Change
- ❑ Address Change
- ❑ Beneficiary Change

Note: Do not use this form to terminate coverage for employees or dependents. To terminate employee or dependent coverage, use a billing statement, SIMON or email to customerservice@bsitpa.com.

Special Enrollment Qualifying Event
- ❑ Involuntary Loss of Coverage
- ❑ Medical Assistance/CHIP
- ❑ Court Order (Dependent Child)
- ❑ Birth
- ❑ Marriage/Domestic Partnership (DP): Date of marriage or DP _____/_____/_____
- ❑ Adoption/Legal Guardian (Legal Documents Required)

EMPLOYER INFORMATION: (To be completed by the Employer)

★Employer Name		★Employee's Date of Hire	/ /	Date Employee entered eligible class (if different than Date of Hire)	/ /

Class (If more than one Class offered by the Employer) ❑ Class 1 ❑ Class 2 ❑ Class 3

Employee's Medical Plan Selection (If more than one Medical Plan offered by the Employer)

❑ Wellness 1	❑ GF Choice 2	❑ GF Choice 4	❑ Solutions 1000	❑ Solutions 2500	❑ Secure 500	❑ GF Secure 1000	❑ Secure 2500	❑ HSA 2000
❑ Wellness 2	❑ Choice 3	❑ Solutions 500	❑ GF Solutions 1000	❑ Solutions 3000	❑ GF Secure 500	❑ Secure 1500	❑ Secure 3000	❑ GF HSA 2000
❑ Choice 1	❑ GF Choice 3A	❑ GF Solutions 500	❑ Solutions 1500	❑ Solutions 4000	❑ Secure 750	❑ GF Secure 1500	❑ Secure 4000	❑ HSA 3000
❑ GF Choice 1	❑ GF Choice 3B	❑ Solutions 750	❑ GF Solutions 1500		❑ GF Secure 750	❑ Secure 2000		❑ GF HSA 3000
❑ Choice 2	❑ Choice 4	❑ GF Solutions 750	❑ GF Solutions 2000		❑ Secure 1000	❑ GF Secure 2000		

EMPLOYEE INFORMATION: (To be completed by the Employee)

★Name: (Last) (First) (M.I.)	★Gender: ❑ Male ❑ Female	★Social Security Number: – –	★Birth Date: / /	★Marital Status: ❑ Single ❑ Married
★Mailing Address: (Street) (City) (State) (Zip)		Phone Number: ( )	Annual Salary (for Salary-Based Life):	

Employee's Prior Coverage Information: Enrollees who have been covered by health insurance during the 3-months prior to enrolling in this plan must provide the following information.	Carrier:	Date Coverage Ended: / /	Date Coverage Began: / /

BENEFICIARY: For Employee's Basic Life / AD&D Insurance Benefit	Beneficiary Name	Beneficiary Address	Relationship

Medical and Dental Plans underwritten by Premera Blue Cross, 7001 220th St. SW Mountlake Terrace, WA 98043; Life Plans by LifeWise Assurance Company, 7007 220th SW, Mountlake Terrace, WA 98043; Vision plans by Vision Service Plan, 600 University St. Ste. 2004, Seattle, WA 98101; EAP by ComPsych Corporation, 455 N Cityfront Plaza Dr, Chicago, IL 60611. Premera Blue Cross is an Independent Licensee of the Blue Cross Blue Shield Association

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EMPLOYEE MEDICAL/DENTAL ENROLLMENT APPLICATION

W/_____

Employer Name:		*Employee Name:*	

DEPENDENT INFORMATION: (To be completed by the Employee)

To enroll a dependent(s), please provide the information below. If you have more than four dependents, please attach a second form. If any listed dependents have a different mailing address than the employee, please attach a separate page with this information. Changes in dependent coverage must comply with the rules governing the Trust, including Qualifying Events as outlined in your benefit booklet. NOTE: Children over the age of 26 require certification.

	★ACTION		★Name First Last	★Birth Date	★Relationship	★Gender	★Social Security #
1	❑ Add Medical ❑ Add Dental	❑ Waive Medical ❑ Waive Dental		/ /	❑ Spouse ❑ Domestic Partner ❑ Son ❑ Daughter ❑ Other: _____	❑ Male ❑ Female	Continue to Line 1 below
2	❑ Add Medical ❑ Add Dental	❑ Waive Medical ❑ Waive Dental		/ /	❑ Son ❑ Daughter ❑ Other: _____	❑ Male ❑ Female	Continue to Line 2 below
3	❑ Add Medical ❑ Add Dental	❑ Waive Medical ❑ Waive Dental		/ /	❑ Son ❑ Daughter ❑ Other: _____	❑ Male ❑ Female	Continue to Line 3 below
4	❑ Add Medical ❑ Add Dental	❑ Waive Medical ❑ Waive Dental		/ /	❑ Son ❑ Daughter ❑ Other:_____	❑ Male ❑ Female	Continue to Line 4 below

Prior Coverage Information: If the dependents listed above had health insurance coverage during the 3-month period before their enrollment date on this plan, please complete section below:

1	Carrier:	Covered under what subscriber's name:	Date Coverage Began: / /	Date Coverage Ended: / /
2	Carrier:	Covered under what subscriber's name:	Date Coverage Began: / /	Date Coverage Ended: / /
3	Carrier:	Covered under what subscriber's name:	Date Coverage Began: / /	Date Coverage Ended: / /
4	Carrier:	Covered under what subscriber's name:	Date Coverage Began: / /	Date Coverage Ended: / /

I hereby apply for enrollment or change of enrollment as indicated on Page 1 and 2 of this application. I understand that WAHIT may collect, use and disclose protected health information for eligibility purposes. The Carriers may collect, use and disclose protected health information about each individual enrolled under this application in order to carry out their routine business functions, including but not limited to, determining eligibility for benefits, paying claims, coordinating benefits with other payers, underwriting and conducting case management care management and quality reviews. WAHIT and the Carriers may also disclose protected health information to state and federal agencies, or other third parties, as required by law. 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.

★Employee Signature	Employee's Email Address (Required for web access)	★Date

Employee eligibility will not be forwarded to the carrier and service providers without employee signature. Please return this form to your employer.