WASHINGTON ALLIANCE FOR HEALTHCARE INSURANCE TRUST

EMPLOYEE MEDICAL/DENTAL ENROLLMENT APPLICATION

W/__________

ENROLLMENT INFORMATION:	★Requested Effective Date of Enrollment or Change ➔	/ 01 /
Reason for Enrollment (Check One) ❑ Open Enrollment (new or renewing groups) ❑ New Hire or new to Eligible Class ❑ COBRA / Continuation - start date ____/_____/___ ❑ Add Dependent(s) (Specify qualifying event at right) ❑ Special Enrollment (Specify qualifying event at right)	**Qualifying Event** ❑ Involuntary Loss of Coverage ❑ Medical Assistance/CHIP ❑ Court Order (Dep. Child) ❑ Birth ❑ Marriage/Domestic Partnership (DP) Date of marriage or DP _____/_____/_____ ❑ Adoption/Legal Guardian (Legal Documents Required)	**Reason for Change** ❑ Name Change ❑ Address Change ❑ Beneficiary Change **Note:** To terminate employee or dependent coverage, use billing statement or iBSI online

EMPLOYER INFORMATION: (To be completed by the employer) (★ indicates mandatory field) PLEASE REVIEW FOR ACCURACY BEFORE SUBMITTING

★Employer Name		★Employee's Date of Hire	/ /	Date Employee entered eligible class (if different than Date of Hire)	/ /
Class (If Applicable)	❑ Class 1	❑ Class 2	❑ Class 3		
Employee's Medical Plan Selection (If Applicable)	❑ Choice 1	❑ Choice 2	❑ Choice 3	❑ Choice 4	❑ HSA 2000
	❑ Solutions 500	❑ Solutions 750	❑ Solutions 1000	❑ Solutions 1500	❑ HSA 3000
	❑ Secure 500	❑ Secure 750	❑ Secure 1000	❑ Secure 1500	❑ Secure 2000

EMPLOYEE INFORMATION: (To be completed by the Employee) (★ indicates mandatory field) PLEASE PRINT CLEARLY

★First Name	Middle	★Last Name	Suffix (Jr, Sr, etc.)	Phone ( )	★Employee's Birth Date / /	★Gender ❑ Male ❑ Female
★Mailing Address		★City	★State	★Zip	Marital Status	★Social Security # – –	Annual Salary (for Salary-Based Life)

Employee's Prior Coverage Information	Enrollees who have been covered by health insurance during the 3 calendar months prior to enrolling in this plan must provide information below:		
	Date Prior Coverage Began	Date Prior Coverage Ended	Name of Prior Insurance Company

DEPENDENT ENROLLMENT: To enroll a dependent(s) provide information below. If you have more than five dependents, please attach a second form. If a dependent wishes to waive either dental or medical, check the appropriate box below. If any of your dependents had health insurance coverage during the prior 3-month period before their enrollment date on this plan, please be certain to provide PRIOR COVERAGE information. Changes in dependent coverage must comply with the rules governing the Trust, including Qualifying Events as outlined in your benefit booklet.

Waive: Dental	Waive: Medical	★Name of Dependent (If dependent has different mailing address, please attach) First Last	★Birth Date (Child over-age 25 requires certification)	★Relationship (Spouse, Domestic Partner, Son, Daughter)	★Gender Circle One	★Social Security #	Prior Coverage Information: Covered under what subscriber's name?	Date Coverage Began	Date Coverage Ended
❑	❑		/ /		M F			/ /	/ /
❑	❑		/ /		M F			/ /	/ /
❑	❑		/ /		M F			/ /	/ /
❑	❑		/ /		M F			/ /	/ /
❑	❑		/ /		M F			/ /	/ /

BENEFICIARY FOR EMPLOYEE'S BASIC LIFE / AD&D INSURANCE BENEFIT:	Beneficiary Name	Beneficiary Address	Relationship

I hereby apply for enrollment or change of enrollment as indicated on 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 a carrier for the purposes of defrauding the carrier. Penalties include imprisonment, fines and denial of coverage.

★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.

Medical and Dental Plans underwritten by Premera Blue Cross, 7001 220th 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.