



WASHINGTON ALLIANCE FOR HEALTHCARE INSURANCE TRUST

EMPLOYEE ENROLLMENT APPLICATION **W/** _____



ENROLLMENT INFORMATION:		Reason for Enrollment				Reason for Change			
★ Requested Effective Date of Enrollment or Change /01/ mm dd yy	(Check One) <input type="checkbox"/> Open Enrollment (new or renewing groups) <input type="checkbox"/> New Hire or new to Eligible Class <input type="checkbox"/> COBRA / Continuation - start date ____/____/____ <input type="checkbox"/> Add Dependent(s) (Specify qualifying event at right) <input type="checkbox"/> Special Enrollment (Specify qualifying event at right)	Qualifying Events for Special Enrollment (See Benefit Booklet) <input type="checkbox"/> Marriage/DomesticPartnership(DP) Date of marriage or DP ____/____/____ <input type="checkbox"/> Involuntary Loss of Coverage <input type="checkbox"/> Medical Assistance/SCHIP <input type="checkbox"/> Court Order (Dep. Child) <input type="checkbox"/> Birth <input type="checkbox"/> Adoption/Legal Guardian (Legal Documents Required)				<input type="checkbox"/> Name Change <input type="checkbox"/> Address Change <input type="checkbox"/> Beneficiary Change <input type="checkbox"/> Delete Dependent			
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)	<input type="checkbox"/> Class 1	<input type="checkbox"/> Class 2	<input type="checkbox"/> Class 3						
Employee's Medical Plan Selection	<input type="checkbox"/> Choice 1	<input type="checkbox"/> Choice 2	<input type="checkbox"/> Choice 3A	<input type="checkbox"/> Choice 3B	<input type="checkbox"/> Choice 4	<input type="checkbox"/> HSA 2000			
	<input type="checkbox"/> Solutions 500	<input type="checkbox"/> Solutions 750	<input type="checkbox"/> Solutions 1000	<input type="checkbox"/> Solutions 1500	<input type="checkbox"/> Solutions 2000	<input type="checkbox"/> HSA 3000			
	<input type="checkbox"/> Secure 500	<input type="checkbox"/> Secure 750	<input type="checkbox"/> Secure 1000	<input type="checkbox"/> Secure 1500	<input type="checkbox"/> 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 <input type="checkbox"/> Male <input type="checkbox"/> Female	
★ Mailing Address			★ City	★ State	★ Zip	Marital Status	★ Social Security # - -	Annual Salary (for STD or 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 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 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. To delete a dependent, check the box next to their name.									
Delete (check box)	★ Name of Dependent (If dependent has different mailing address, please attach)		★ Birth Date (Child over Age 25 requires certification)	★ Relationship (Spouse, Domestic Partner, Son, Daughter)	★ Gender Circle One	★ Social Security #	Prior Coverage Information		
	First	Last					Covered under what subscriber's name?	Date Coverage Began	Date Coverage Ended
<input type="checkbox"/>			/ /		M F			/ /	/ /
<input type="checkbox"/>			/ /		M F			/ /	/ /
<input type="checkbox"/>			/ /		M F			/ /	/ /
<input type="checkbox"/>			/ /		M F			/ /	/ /
<input type="checkbox"/>			/ /		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 purpose of defrauding the carrier. Penalties include imprisonment, fines and denial of coverage.

★ Employee Signature	Employee's Email Address (Required for web access)	★ Date
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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 LifeWise Health Plan of WA, 7001 220th SW Mountlake Terrace, WA 98043; Life/Disability 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. It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purposes of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.