

PO Box 91059

Seattle, WA 98111-9159

www.premera.com

 MEMBER ENROLLMENT AND CHANGE APPLICATION

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| 1. GROUP INFORMATION (to be completed by the group) |
| Group ID | Group name | Employee class/subgroup (as applicable) | Employee Date of Hire**/    /** |
| Enrollment Reason | If COBRA, indicate number of months eligible for coverage:[ ]  18 months [ ]  29 months [ ]  36 months | Date of enrollment details [ ]  Same as hire date [ ]  Other date **/    /** | Plan start date**/    /** |
| 2. EMPLOYEE INFORMATION (employee to complete sections 2 through 4) |
| Employee name (Last) | (First) |  | Contact phone( )  | Contact email (\*Required) |
| Mailing address | City | State | ZIP |
| 3. ENROLLMENT INFORMATION |
| Plan choice (as applicable) | ***NOTE:*** *Please indicate names as you would like it to appear on the ID card.* ***ID card names are limited to 26 characters and spaces.*** |
| **Add** | **Drop** | **Relationship to Employee** | **Last Name** | **First Name** | **Social Security No.****(\*Required)** | **Date of Birth** | **Gender** | **Benefit Selection** |
|  |  |  |  |  |  |  | **M** | **F** | **Medical** | **Dental** | **Vision Only** |
| [ ]  | [ ]  | Self |  |  |  | **/    /** | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| [ ]  | [ ]  |  |  |  |  | **/    /** | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| [ ]  | [ ]  |  |  |  |  | **/    /** | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
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| [ ]  | [ ]  |  |  |  |  | **/    /** | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| If any dependent has a different mailing address, please attach that information. Additional information attached? [ ]  No [ ]  Yes |
| If any child over the dependent age limit is applying for coverage due to disability, please complete and attach the ***Request for Certification of Disabled Dependent*** form. |
| Please complete and attach the ***Other Coverage Questionnaire*** form if any applicant has other current health coverage, including Medicare or Premera, which will remain in effect when your Premera coverage begins. If the form is not included, then it is assumed that no other coverage is in effect. |
| 4. EMPLOYEE SIGNATURE |
| In applying for enrollment as indicated on this application, I declare that all of the information on this form is true and complete to the best of my knowledge. I also declare that each person I am requesting enrollment for is eligible for coverage. I have also read and understand the provisions as stated in section 5 of this document. The changes on this form supersede all previous forms submitted.Employee signature Date signed / / ***Please note:*** *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.*  |

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| 4. PLEASE READ |

Premera Privacy Policy

We may collect, use, or disclose personal information about you, such as health information, your address, telephone number or Social Security number. We may exchange this information with healthcare providers, insurance companies, or other sources to conduct our routine business operations. Examples are deciding if you qualify for coverage; paying claims; coordinating benefits with other healthcare plans; or conducting care management, case management, or quality reviews. We may also collect, use or release your personal information as required or permitted by law.

To safeguard your privacy and make sure we keep your information remains confidential, we train all employees on our written confidentiality policy and procedures. If a disclosure of your personal information is not related to a routine business function, we will remove anything that could be used to easily identify you, unless we have your prior approval to release such information.

You have the right to ask to look at or change your records retained by us. To view or print copies of our detailed Privacy Notice and other forms, please visit our web site at [premera.com](http://www.premera.com). To have forms mailed to you, please call the number below.

Special Enrollment Rights

If you are declining enrollment for yourself or dependents because of other health care coverage, you may in the future enroll yourself or your dependents in this plan prior to the next open enrollment period. To do this, you must have involuntarily lost your other coverage and we must receive your enrollment application within 60 days after your other coverage ended (60 days if the prior coverage was through Medicaid or CHIP). Additionally, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and dependents, provided we receive your completed enrollment application within 60 days after the marriage, birth, adoption, or placement for adoption, unless a different time limit has been specified in your benefit booklet.

\*Required social security number and contact email address

Under the Affordable Care Act (ACA), all health plans must provide an IRS Form 1095-B to fully insured members starting in 2016. You’ll need Form 1095-B to help file your taxes, much like your W-2.

**If you have any questions about the information included in this notice, please call us at 1-800-508-4722.**

