WORKING WATERFRONT COALITION
HEALTH TRUST

Employee Enrollment Application, Cancellation, and Waiver

Effective Date of Enrollment, Termination or Change:		**Employer Name:**		**Class: Medical Plan:**	

Check One: ❑ New Enrollee ❑ Cancellation ❑ Name Change ❑ Add Dependents ❑ Delete Dependents ❑ Address Change ❑ Waiving ❑ COBRA

Personal Information: (Please Print Clearly)

Employee Name:	Last:			**SSN:**	
	First:	M.I:		**Date of Birth:**	_____ / _____ / _____
Mailing Address:				**Hire Date:**	_____ / _____ / _____
City:		**State:**	**Zip Code:**	**Hours per week:**	
Phone:		**Marital Status:**	**Date of Marriage or Domestic Partnership:**	**Gender:**	❑ Male ❑ Female

Name of Enrolling Dependent(s):	**Birth Date:**	**Relationship to Employee:**	**Sex:**	**SSN:**	**Election**	
					Medical:	**Dental:**
1)		❑Spouse ❑Child ❑Domestic Partner	❑Male ❑Female		❑ Add ❑ Delete	❑ Add ❑ Delete
2)		❑Child	❑Male ❑Female		❑ Add ❑ Delete	❑ Add ❑ Delete
3)		❑Child	❑Male ❑Female		❑ Add ❑ Delete	❑ Add ❑ Delete
4)		❑Child	❑Male ❑Female		❑ Add ❑ Delete	❑ Add ❑ Delete
5)		❑Child	❑Male ❑Female		❑ Add ❑ Delete	❑ Add ❑ Delete
6)		❑Child	❑Male ❑Female		❑ Add ❑ Delete	❑ Add ❑ Delete

Beneficiary for Basic Life / AD&D Insurance Benefit

Name:		**Relationship:**	
Address:			

Current Coverage, Prior Coverage and **Coordination of Benefits:**
If you or any dependent currently has or has had other group medical coverage (including Medicare) within the last three calendar months, please complete below.

Name of Family Member:	**Other Employer (or Medicare):**	**Date Coverage Began:**	**Date Coverage Ended:**	**Name of Insurance Carrier:**	**Group Number:**

By signing below, I acknowledge that I have read, understand and agree to the Terms & Conditions on all pages of this form.

Employee Signature	**Date**

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Terms & Conditions

Application Agreement

I hereby apply for coverage under the contract between the issuer and my employer or group, and I agree with the terms of the contract. I also apply for the same coverage for my spouse or domestic partner, and/or my children listed on this application. I attest that my listed dependents and I meet all the eligibility criteria set forth in the outline of benefits and/or the contract.

I agree to pay in advance the appropriate rates for myself and listed dependents and authorize rate increases as the company deems necessary.

Anti-Fraud Statement

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. I have provided these answers as part of the application procedure required by the issuer to enroll in coverage and I attest that all information completed on this form is true, correct, and complete. I understand that the issuer will rely on each answer in making coverage and rating determinations.

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.

Medical Coverage Underwritten by: **Premera Blue Cross;** 7001 220th St SW; Mountlake Terrace, WA 98043-2160 **Premera Blue Cross HMO;** 7001 220th St SW; Mountlake Terrace, WA 98043-2160
Dental Coverage Underwritten by: **Delta Dental of Washington;** 400 Fairview Avenue North, Suite 800, Seattle, WA 98109
Vision Coverage Underwritten by: **VSP Vision Care, Inc**. (HCSC)**;** 3333 Quality Drive; Rancho Cordova, CA 95670
Life/AD&D Coverage Underwritten by: **USAble Life;** P.O. Box 1650 Little Rock, AR 72223

*Administered by **Vimly Benefit Solutions***

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