Combined Insurance Enrollment Form

Complete entire form to enroll or make changes.

Enrollment

- ❑ New hire
- ❑ New group
- ❑ Open enrollment for medical & dental only

Changes Has there been a change that affects your insurance? Please fill in your name and SSN.
Then check **all the changes** that apply to you **and complete the entire form.**

❑ Name ❑ Address ❑ Marriage ❑ Domestic Partnership ❑ Divorce ❑ Legal separation ❑ Beneficiary

❑ Other (be specific) _____

❑ Add dependent (check reason) ❑ Marriage ❑ Domestic Partnership ❑ Newborn

❑ Other reason (be specific) _____

❑ Drop dependent (check reason) ❑ Overage dependent

❑ Other reason (be specific) _____

Employee

Please print legibly in blue or black ink.

SSN | Employee Name (last, first, initial) | Date of birth | Gender

❑ Single ❑ Married Date married: ❑ Divorced Date divorced:

❑ Domestic partnership Date met DP criteria: ❑ Partnership termination Date terminated:

Home / mailing address | Home phone (with area code)

City | State | Zip

Type of coverage requested (check all that apply): ❑ Medical ❑ Dental ❑ Life ❑ Long-term disability ❑ Vision ❑ EAP
Carriers and specific plans are listed on the back of this form.

Are you covered by any other insurance now or in the past three months? ❑ Yes ❑ No If yes, complete below.

Effective date | Termination date

Insured's SSN | Name (last, first, initial)

Group# | Policy # | Type of insurance (medical. dental, etc.) | Name of other insurance company

Spouse/Domestic Partner

Please list spouse/domestic partner who should be covered on your insurance. Leaving them off will terminate coverage. Proof of dependency may be requested, including, but not limited to, marriage certificate, affidavit of marriage/domestic partnership, divorce papers.

SSN | Spouse/DP name (last, first, initial) | Date of birth | Gender

Type of insurance requested: ❑ Medical ❑ Dental ❑ Vision ❑ Life

Is spouse/domestic partner covered by any other insurance now or in the past three months? ❑ Yes ❑ No

If yes, name of other insurance company. | Type of insurance (medical, dental, etc.)

Group / Policy # | Phone #

Effective date | Termination date

Your signature is required on page 3 of this form.

Dependents

Please list all dependents that should be covered on your insurance. Leaving them off the form will terminate coverage. Proof of dependency may be requested, but not limited to, birth certificate, adoption papers. **Medical, Dental & Vision**: A dependent is a child, stepchild or adopted child; less than age 26 **or** prior to age 26 was incapable of self-support due to developmental disabilities or physical handicap (proof of incapacity required). **Life**: A dependent is a child, stepchild or adopted child from birth but less than age 26.

Dependent #1_____

Please check all appropriate boxes and fill in the appropriate blanks. For addi-tional dependents, please fill out additional forms and alter "Dependent #____."

Name (last, first, middle initial)

SSN

Gender Date of birth Relationship to insured

Type of insurance requested: ❑ Medical ❑ Dental ❑ Vision ❑ Life

Is dependent covered by any other insurance now or in the past three months? ❑ Yes ❑ No

If yes, name of other insurance company & type (medical, dental, etc.)

Name of insured (last, first, intial) SSN of insured

Group/policy # Effective date Termination date

Does he/she live with you? ❑ Yes ❑ No

If no, name of person with whom he/she resides

Last, first, intitial SSN

Home address Home phone

City State Zip

If divorced, do you have custody? ❑ Yes ❑ No

If no, name of person with custody (last, first, intial) SSN

Home address Home phone

City State Zip

Dependent #2_____

Please check all appropriate boxes and fill in the appropriate blanks. For addi-tional dependents, please fill out additional forms and alter "Dependent #____."

Name (last, first, middle initial)

SSN

Gender Date of birth Relationship to insured

Type of insurance requested: ❑ Medical ❑ Dental ❑ Vision ❑ Life

Is dependent covered by any other insurance now or in the past three months? ❑ Yes ❑ No

If yes, name of other insurance company & type (medical, dental, etc.)

Name of insured (last, first, intial) SSN of insured

Group/policy # Effective date Termination date

Does he/she live with you? ❑ Yes ❑ No

If no, name of person with whom he/she resides

Last, first, intitial SSN

Home address Home phone

City State Zip

If divorced, do you have custody? ❑ Yes ❑ No

If no, name of person with custody (last, first, intial) SSN

Home address Home phone

City State Zip

Life Insurance

Beneficiaries

For life insurance policies as underwritten by Standard Life Insurance only. Please note that in community property states, including Washington, the spouse has legal right to 50% of the benefits, in the event of the employee's death.

Name of primary beneficiary (last, first, initial)

SSN

Address

City State Zip

Relationship to insured Percent of proceeds

Name of contingent beneficiary #1 (last, first, initial)

SSN

Address

City State Zip

Relationship to insured Percent of proceeds

Name of contingent beneficiary #2 (last, first, initial)

SSN

Address

City State Zip

Relationship to insured Percent of proceeds

Name of contingent beneficiary #3 (last, first, initial)

SSN

Address

City State Zip

Relationship to insured Percent of proceeds

Your Signature is Required

I hereby verify that all of the information specified on this form is accurate and complete. By signing below, I have authorized the release of information for myself and my dependents listed on this form to the carriers (listed on back of this form) that cover me and my family members (if applicable). Please note that failure to fully complete this enrollment form may result in this form being returned to you and will delay processing of the form.

I hereby apply for coverage under the contract between the respective insurance company and my employer and AWC, and I agree with the terms of the contract. I also apply for the same coverage for my spouse and/or dependent children listed on this application. I certify that my dependents and I meet all the eligibility criteria set forth in the outline or benefits and/or the Contract.

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 acknowledgment does not apply to obtaining information regarding psychotherapy notes. A separate authorization will be used for psychotherapy notes.

For the protection of all of our members, fraud or misrepresentation of material fact by me for the purposes of defrauding the insurance company may result in the insurance company taking any action allowed by law or Contract, including termination or rescission of coverage, denial of benefits, and/or pursuit of criminal charges and penalties.

**For more information about such uses and disclosures, including uses and disclosures required by law, please refer to the individual insurance carrier Consumer Privacy Notices by contacting the carrier directly.*

Signature

Date

Please Note

Failure to fully complete this form may result in this form being returned to you and will delay the processing of the form.

Employer

Employer

Employees: Employer will complete this section.
Send completed form to: **1076 Franklin Street S.E., Olympia, WA 98501-1346**

Employer name			Date of hire	Effective date of change
Employee's occupation	Weekly hours	Monthly base earnings	Dept. name	Dept. number

Type of enrollee: ❑ Active ❑ LEOFF I Active ❑ LEOFF I Retiree

Employer – Please note that failure to fully complete this form may result in this form being returned to you and will delay the processing of the form. Please proof this form carefully.

Plans Enrolled On (Please check all that apply.)

Medical

Regence
Regence BlueShield is an Independent Licensee of the Blue Cross and Blue Shield Association

PO Box 21267
Seattle, WA 98111

❑ **Regence BlueShield**
- ❑ AWC HealthFirst™
- ❑ AWC HealthFirst 250™
- ❑ AWC HealthFirst 500™
- ❑ High Deductible Health Plan
- ❑ Plan A
- ❑ Plan B

ASURIS NORTHWEST HEALTH

PO Box 91130
Seattle, WA 98111

❑ **Asuris Northwest Health**
- ❑ AWC HealthFirst™
- ❑ AWC HealthFirst 250™
- ❑ AWC HealthFirst 500™
- ❑ High Deductible Health Plan
- ❑ Plan A
- ❑ Plan B

GroupHealth

PO Box 34750
Seattle, WA 98124

❑ **Group Health Cooperative**
- ❑ No CoPay
- ❑ $5 CoPay
- ❑ $ 10 CoPay
- ❑ $20 Copay, $200 Deductible Plan
- ❑ High Deductible Health Plan

Dental

DELTA DENTAL
Washington Dental Service
Washington Dental Service is a member of the Delta Dental Plans Association

Northgate Delta Building
PO Box 75983
Seattle, WA 98175

Washington Dental Service

Basic (0177)
- ❑ Plan A
- ❑ Plan B
- ❑ Plan C
- ❑ Plan D
- ❑ Plan E
- ❑ Plan F
- ❑ Plan G
- ❑ PPO Plan

Orthodontia
- ❑ Option I
- ❑ Option II
- ❑ Option III
- ❑ Option IV
- ❑ Option V

WILLAMETTE DENTAL®

6950 NE Campus Way
Hillsboro, OR 97124

Willamette Dental
- ❑ $ 10 CoPay
- ❑ $ 15 CoPay

Vision

vsp Vision care for life

PO Box 997105
Sacramento, CA 95899-7105

Vision Service Plan (071038Z2)
- ❑ No Deductible (0001)
- ❑ $10 Deductible (0002)
- ❑ $25 Deductible (0005)
- ❑ Low Option Plan
- ❑ Second Pair Rider

Employee Assistance Program

ComPsych®
The GuidanceResources Company®

NBC Tower
455 N. Cityfront Plaza Drive
Chicago, IL 60611-5322

ComPsych
- ❑ 1-3 Sessions
- ❑ 1-5 Sessions
- ❑ 1-8 Sessions

Life

TheStandard
Positively different.

900 SW Fifth Ave.
Portland, OR 97204

Standard Insurance
- ❑ Basic Life
  $ _____
- ❑ Accidental Death & Dismemberment
- ❑ Dependent Life
  - ❑ Plan Option 1
  - ❑ Plan Option 2
- ❑ Employee Supplemental Life
  $ _____
  Note: EOI form required if over $20,000.
- ❑ Spouse Supplemental Life
  $ _____
  Note: Cannot exceed 50% of Employee Supp. Life. EOI required.

Long-term Disability

TheStandard
Positively different.

900 SW Fifth Ave
Portland, OR 97204

Standard Insurance
- ❑ 90-Day: 60% Benefit
- ❑ 90-Day: 67% Benefit
- ❑ 180-Day: 60% Benefit
- ❑ 180-Day: 67% Benefit