AWC EMPLOYEE BENEFIT TRUST

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

Comments _____

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). Any preexisting condition waiting period does not apply to any members under the age of 19. **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 additional 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 additional 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/domestic partner and/or dependents 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.

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.

**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

1800 Ninth Ave
Seattle, WA 98101

☐ **Regence BlueShield**
- ❑ AWC HealthFirst®
- ❑ AWC HealthFirst® 250
- ❑ AWC HealthFirst® 500
- ❑ High Deductible Health Plan
- ❑ Plan A – LEOFF I only

ASURIS NORTHWEST HEALTH

528 E Spokane Falls Blvd, Suite 301
Spokane, WA 99202

☐ **Asuris Northwest Health**
- ❑ AWC HealthFirst®
- ❑ AWC HealthFirst® 250
- ❑ AWC HealthFirst® 500
- ❑ High Deductible Health Plan
- ❑ Plan A – LEOFF I only

GroupHealth

320 Westlake Ave N, Suite 100
Seattle, WA 98109-5233

☐ **Group Health Cooperative**
- ❑ $10 Copay
- ❑ $20 Copay, $200 Deductible Plan
- ❑ High Deductible Health Plan
- ❑ No Copay – LEOFF I only

☐ **Group Health Options, Inc.**
- ❑ $250 Deductible Plan

Dental

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

9706 Fourth Ave NE
Seattle, WA 98115

Washington Dental Service

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

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

Willamette Dental Group

6950 NE Campus Way
Hillsboro, OR 97124

Willamette Dental of Washington, Inc.
- ❑ $10 Copay
- ❑ $15 Copay

Vision

VSP Vision Care for Life

3333 Quality Drive
Rancho Cordova, CA 95670

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®

1100 SW 6th Ave
Portland, OR 97204

Standard Insurance Company
- ❑ Basic Life
  $ _____
- ❑ Accidental Death & Dismemberment
- ❑ Dependent Life
  - ☐ Plan Option 1
  - ☐ Plan Option 2
- ❑ Employee Additional Life
  $ _____
  Note: EOI form required if over $80,000.
- ❑ Spouse Additional Life
  $ _____
  Note: Cannot exceed 50% of employee additional life. EOI required, if over $20,000.

Long-term Disability

TheStandard®

1100 SW 6th Ave
Portland, OR 97204

Standard Insurance Company
- ❑ 90-day: 60% Benefit
- ❑ 90-day: 67% Benefit
- ❑ 180-day: 60% Benefit
- ❑ 180-day: 67% Benefit