Combined insurance enrollment form

Complete entire form to enroll or make changes.

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.

Employer

Employer to complete this section and send completed form to AWC at benefitinfo@awcnet.org or fax to 360.753.0149 or mail to 1076 Franklin Street SE, Olympia, WA 98501-1346

Employer name | Date of hire | Effective date of change

Employee's occupation | Class/bargaining unit

Salary ☐Annual $ ☐Monthly $ ☐Weekly $ ☐Hourly $

Enrollment

☐New hire
☐New group
☐Open enrollment January 1

Changes

Has there been a change that affects your insurance? 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 ☐Divorced Date divorced: _____

☐Partnership termination Partnership termination date: _____

Mailing address | Phone (with area code)

City | State | Zip | Email address

Type of coverage requested (check all that apply): ☐Medical ☐Dental ☐Vision ☐Life ☐Long-term disability ☐EAP

Carriers and specific plans are listed on the back of this form.

Are you adding this coverage due to a recent loss of coverage? ☐Yes ☐No If yes, complete below.

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

Effective date _____ Termination date _____

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

Spouse/ Domestic Partner

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

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

Date married: _____ Date met DP criteria: _____

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

Are you adding this coverage due to a recent loss of coverage? ☐ Yes ☐ No If yes, complete below.

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

Effective date _____ Termination date _____ Phone # _____

Dependents

Please list all dependents that should be covered on your insurance. Leaving them off the form will terminate coverage. Proof of dependency will 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.

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

Dependent #1

Name (last, first, middle initial)

SSN

Gender | Date of birth | Relationship to insured

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

Are you adding this coverage due to a recent loss of coverage? ☐ Yes ☐ No

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

Name of insured (last, first, initial) | SSN of insured

Group/policy # | Effective date | Termination date

Does he/she live with you? ☐ Yes ☐ No

Mailing address | Home phone

City | State | Zip

Dependent #2

Name (last, first, middle initial)

SSN

Gender | Date of birth | Relationship to insured

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

Are you adding this coverage due to a recent loss of coverage? ☐ Yes ☐ No

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

Name of insured (last, first, initial) | SSN of insured

Group/policy # | Effective date | Termination date

Does he/she live with you? ☐ Yes ☐ No

Mailing address | Home phone

City | State | Zip

Dependents

Please list all dependents that should be covered on your insurance. Leaving them off the form will terminate coverage. Proof of dependency will 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.

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

Dependent #3

Name (last, first, middle initial)

SSN

Gender | Date of birth | Relationship to insured

Type of insurance requested:

☐ Medical ☐ Dental ☐ Vision ☐ Life

Are you adding this coverage due to a recent loss of coverage? ☐ Yes ☐ No

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

Name of insured (last, first, initial) | SSN of insured

Group/policy # | Effective date | Termination date

Does he/she live with you? ☐ Yes ☐ No

Mailing address | Home phone

City | State | Zip

Dependent #4

Name (last, first, middle initial)

SSN

Gender | Date of birth | Relationship to insured

Type of insurance requested:

☐ Medical ☐ Dental ☐ Vision ☐ Life

Are you adding this coverage due to a recent loss of coverage? ☐ Yes ☐ No

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

Name of insured (last, first, initial) | SSN of insured

Group/policy # | Effective date | Termination date

Does he/she live with you? ☐ Yes ☐ No

Mailing 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 | Date of birth

Address

City | State | Zip

Relationship to insured | Percent of proceeds

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

SSN | Date of birth

Address

City | State | Zip

Relationship to insured | Percent of proceeds

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

SSN | Date of birth

Address

City | State | Zip

Relationship to insured | Percent of proceeds

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

SSN | Date of birth

Address

City | State | Zip

Relationship to insured | Percent of proceeds

Your signature is required

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

By signing below, I represent the following:

- I am applying for the selected coverage(s) for myself and, if applicable, for my family members who are listed on this form.
- My family members and I meet all of the eligibility criteria to apply for such coverage(s), and I understand that proof of dependency will be requested for enrollment of my family members.
- All information I have provided on this form is accurate and complete.
- I understand that it is a crime to knowingly provide false, incomplete, or misleading information for purposes of defrauding the Trust, a health plan, or an insurance company, with penalties including denial of coverage, fines, and/or imprisonment.

I authorize the release of information about me and my family members to the insurance companies listed on back of this form for purposes of enrolling and receiving benefits under my selected coverage(s).

If I am enrolling in health plan coverage, I acknowledge and understand that the health plan may use or disclose personal health information about me or my enrolled family members to the extent permitted by law, including to facilitate our health care treatments and payments and to otherwise support health plan operations and administration. I understand that I can learn more about how the health plan may use or disclose personal health information by reviewing the Notice of Privacy Practices issued by the health plan. I understand that I can request to receive a copy of this Notice at any time.

Signature _____

Date _____

Select benefits on the next page.

Employee plan enrollment (Please check all that apply.)

Medical

Regence
1111 Lake Washington Blvd N.
Suite 900
Renton, WA 98057
☐ **Regence BlueShield**
- ☐ AWC HealthFirst® 250
- ☐ AWC HealthFirst® 500
- ☐ High Deductible Health Plan

ASURIS NORTHWEST HEALTH
528 E Spokane Falls Blvd,
Suite 301
Spokane, WA 99202
☐ **Asuris Northwest Health**
- ☐ AWC HealthFirst® 250
- ☐ AWC HealthFirst® 500
- ☐ High Deductible Health Plan

KAISER PERMANENTE
2715 Naches Ave. SW
Renton, WA 98057
☐ **Kaiser Foundation Health Plan of Washington**
- ☐ $200 Deductible Plan
- ☐ $500 Deductible Plan
- ☐ High Deductible Health Plan

KAISER PERMANENTE
2715 Naches Ave. SW
Renton, WA 98057
☐ **Kaiser Foundation Health Plan of Washington Options, Inc.**
- ☐ Access PPO

☐ **Decline medical coverage**

Dental

DELTA DENTAL
Delta Dental of Washington
400 Fairview Ave N
Seattle, WA 98109-5371
Delta Dental of Washington Basic (0177)
- ☐ Plan A
- ☐ Plan B
- ☐ Plan C
- ☐ Plan D
- ☐ Plan E
- ☐ Plan F
- ☐ Plan G
- ☐ Plan J

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.
- ☐ $I0 copay
- ☐ $I5 copay

Life

TheStandard®
1100 SW 6th Ave
Portland, OR 97204
Standard Insurance Company
- ☐ Basic life w/AD&D
  $ _____
- ☐ Dependent life
  - ☐ Plan option 1
  - ☐ Plan option 2
  - ☐ Plan option 3
  - ☐ Plan option 4
- ☐ Employee additional life
  $ _____
  Note: EOI form required if over $80,000.
- ☐ Spouse additional life
  $ _____
  Note: EOI form required if over $20,000.

Vision

vsp vision care
3333 Quality Drive
Rancho Cordova, CA 95670
Vision Service Plan (071038Z2)
- ☐ No copay
- ☐ $10 copay
- ☐ $25 copay
- ☐ $10/$15 copay plan
- ☐ Second pair rider

Employee Assistance Program

ComPsych® GuidanceResources® Worldwide
NBC Tower
455 N. Cityfront Plaza Drive
Chicago, IL 60611-5322
ComPsych
- ☐ 1-6 sessions - Included when enrolled on any AWC Trust plan
- ☐ 1-8 Buy-up
- ☐ 1-10 Buy-up

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