

# Business Health Trust Employee Enrollment / Change Form



Employer Name	Effective Date of Coverage  / /	Date of Hire / Qualifying Event  / /	Reason For Enrollment / Qualifying Event <input type="checkbox"/> Hire/Rehire <input type="checkbox"/> Loss of Coverage <input type="checkbox"/> Birth/Adoption <input type="checkbox"/> Open Enrollment <input type="checkbox"/> Address/Name Change <input type="checkbox"/> Add Dependents <input type="checkbox"/> Delete Dependents <input type="checkbox"/> Other: _____
Group #:			<input type="checkbox"/> COBRA <input type="checkbox"/> Extension <input type="checkbox"/> Termination Coverage    Date: _____ COBRA / Extension Eligibility Date: _____ COBRA / Extension Effective Date: _____    Termination Date: _____

**EMPLOYEE INFORMATION: PLEASE PRINT CLEARLY**

First Name, Middle Initial, Last Name				Employee's Birth Date  / /		Gender <input type="checkbox"/> M <input type="checkbox"/> F		Social Security #	
Mailing Address			City	State	Zip	Phone		Annual Salary	Occupation

**PLAN SELECTIONS**

Medical *If no coverage selected, please attach waiver form.  If Medical coverage is waived, participant will not be enrolled in the groups' basic life benefit.	Underwritten by Asuris Northwest Health (ANH):				Underwritten by Group Health Options, Inc.					
	<input type="checkbox"/> Progressive \$0 100/80/50 \$25 <input type="checkbox"/> Progressive \$200 90/80/60 \$20 <input type="checkbox"/> Progressive \$500 100/80/80/50 \$25 <input type="checkbox"/> Progressive \$650 100/80/80/50 \$25		<input type="checkbox"/> PPO Infinity \$200 \$25 <input type="checkbox"/> PPO Infinity \$300 \$25 <input type="checkbox"/> PPO Infinity \$500 \$25		<input type="checkbox"/> PPO Infinity \$1,000 \$25 <input type="checkbox"/> PPO Infinity \$2,000 \$25 <input type="checkbox"/> PPO Infinity \$3,000 \$25		<input type="checkbox"/> HSA 1500 80/80/60 <input type="checkbox"/> HSA 2500 80/80/60 (80% RX Included)		<input type="checkbox"/> Alliant Plus 200 Balance <input type="checkbox"/> Alliant Plus 500 Mid Plan <input type="checkbox"/> Alliant Plus 1000 Balance Plan <input type="checkbox"/> Alliant Plus 3000 50/50 Plan	
	One Prescription Drug Benefit below MUST BE SELECTED with ANH Medical Except HSA Plans								Group Health Plans Include RX Benefits	
Prescription Drug Benefits Underwritten by Asuris NW Health (ANH) <input type="checkbox"/> \$10/\$20/\$40 No deductible 2x mail <input type="checkbox"/> \$10/\$25/\$50 No deductible 3x mail MAC A <input type="checkbox"/> \$10/\$35/\$70 \$150 brand deductible 3x mail MAC A <input type="checkbox"/> \$10/\$35/\$70 No deductible 3x mail MAC A										

Dental Plan Underwritten by: Washington Dental Service	<input type="checkbox"/> Child Orthodontia Rider <input type="checkbox"/> Family Orthodontia Rider <input type="checkbox"/> Plan A <input type="checkbox"/> Plan AA <input type="checkbox"/> Plan C <input type="checkbox"/> Plan F <input type="checkbox"/> Plan G <input type="checkbox"/> Plan GG <input type="checkbox"/> Plan H <input type="checkbox"/> Plan J	Vision Plan Underwritten by: Vision Service Plan	<input type="checkbox"/> Vision Service Plan Signature Plan B 12/12/24 <input type="checkbox"/> Vision Service Plan Signature Choice 12/24/24
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**ENROLEE INFORMATION**

*Add or Delete (Circle One)	*Name of Dependent (If dependent has different mailing address, please attach) First                      Last	*Birth Date (Over Age 25 requires certificate) / /	*Coverage (Circle all that apply) Med    Dent    Vis	*Gender (Circle One) M    F	Social Security #	Prior Coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No (if 'Yes' indicate Prior Coverage Below)	
						Primary Care Physician (PCP) Required for Selections Plans	Primary Care Physician (PCP) ID Number
Add/Delete	Spouse/DP	/ /	Med    Dent    Vis	M    F			
Add/Delete	Child	/ /	Med    Dent    Vis	M    F			
Add/Delete	Child	/ /	Med    Dent    Vis	M    F			
Add/Delete	Child	/ /	Med    Dent    Vis	M    F			
Add/Delete	Child	/ /	Med    Dent    Vis	M    F			

For individuals who are eligible for enrollment in an employer group health plan: If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or employer group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if, in the case of employer group health plan coverage, the employer stops contributing toward you or your dependents' other coverage.) However, you must request enrollment within 30 Days after you or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). In addition, if you gain a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 60 days after the marriage, birth, adoption, or placement adoption.

**Prior Medical Coverage (Preexisting condition waiting period is 3 months. Period may be credited with prior, continuous coverage).**

Prior Medical Carrier and Policy #:	List all participants enrolled in prior medical plan:	Effective Date: _____
		Termination Date: _____

**ADDITIONAL PLAN SELECTIONS**

Basic Life and AD&D Underwritten by Regence Life and Health	Basic Life and AD&D coverage is included when a medical plan is elected. Reductions: All Life & AD&D benefits reduce from the original amount to 65% at age 65, 50% at age 70, 30% at age 75, 20% at age 80 and terminate at retirement. (Amounts above the Guarantee Issue require a completed Evidence of Insurability form) GI Groups size = 5 - 9 = \$50,000 10 - 49 = \$75,000 50 - 99 = \$100,000		
Voluntary Life and AD&D Underwritten by Regence Life and Health	Increases of \$5,000 to a maximum of \$200,000 In no event shall the combined Basic and Voluntary benefits exceed \$250,000. (Available if employer elects coverage) <input type="checkbox"/> Employee Amount _____ <input type="checkbox"/> Spouse Amount (cannot exceed 50% of employee amount) _____		
Long Term Disability Underwritten by Regence Life and Health	Available when employer elects a Long Term Disability (LTD) plan. Coverage at 60% of employee salary subject to the plan maximum and elimination period. (If you waive coverage and elect to enroll at a later date you will need to submit satisfactory Evidence of Insurability before you can be insured under the LTD plan.)		
Alternative Dental Option	Underwritten by Dental Health Services <input type="checkbox"/> SmartSmile <input type="checkbox"/> Super SmartSmile	Employee Assistance Plan	<input type="checkbox"/> Wellspring Family Services (1 -3 Visit model)
Group Legal Plan	<input type="checkbox"/> 21 <sup>st</sup> Century Legal Plan (Complete separate 21 <sup>st</sup> Century Legal Plan form)	Voluntary Personal Accident	<input type="checkbox"/> Provided by Chartis Property Casualty Company (Complete separate enrollment form)

EMPLOYEE BENEFICIARY:	Primary Beneficiary Name and Relationship* for Basic Life/AD&D and Voluntary Life and/or AD&D	Primary Beneficiary Address
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EMPLOYEE BENEFICIARY:	Contingent Beneficiary Name and Relationship** for Basic Life/AD&D and Voluntary Life and/or AD&D	Contingent Beneficiary Address
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\* If more than one primary beneficiary is named, the primary beneficiaries shall share equally unless otherwise indicated above. \*\* Contingent Beneficiary(ies) will only receive proceeds if all Primary Beneficiaries have predeceased the Insured. If you are naming more than one Contingent Beneficiary at 100% each, please indicate them in order of precedence. In community property states, 50% of the payable benefit will be paid to the spouse unless the spouse signs a statement waiving the rights to the proceeds.

**Coordination of Benefits**

Other Insurance Carrier:	Policy ID #:	Effective Date:
Policy Holder's Name:	Phone #:	Date of Birth:
		Social Security #:
If you have Medicare What is the Begin date for:	Part A:	Part B:
		Medicare HIC # with Alpha Suffix:

Asuris Northwest Health: 528 E. Spokane Falls Blvd, Ste 301 Spokane, WA 99202 - Group Health Options, Inc.: 320 Westlake Avenue, Suite 100 Seattle, WA 98109  
 Washington Dental Service: 9706 4th Avenue NE Seattle, WA 98115 - Regence Life and Health Insurance: 100 S.W. Market St.; Portland, OR 97201-5702  
 Dental Health Services: 936 N. 34th Street, Suite 208 Seattle, WA 98103 - Vision Service Plan: 600 University St. Suite 2004 Seattle, WA 98101 - Wellspring Family Services: 615 2nd Avenue, Suite 150 Seattle, WA 98104  
 Chartis Property Casualty Company: 100 Connell Drive Berkley Heights, New Jersey 07922 - 21st Century Legal Plan: 401 Second Avenue South, Suite 700 Seattle, WA 98104

**SIGNATURE**

I have provided these answers as part of the application procedure required by the carrier to enroll in coverage and I certify that all information completed on this form is true, correct, and complete. I understand that the carrier will rely on each answer in making coverage and rating determinations. For the protection of all of our members, fraud or misrepresentation of material fact by me for the purposes of defrauding the carrier may result in the carrier 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.

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. \*For more information about such uses and disclosures, including uses and disclosures required by law, please refer to the Notice of Privacy Practices. A copy is available from the Asuris Northwest Health website at [www.wa.asuris.com](http://www.wa.asuris.com).

Employee Signature	Date	Employer Signature	Date
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