BUSINESS HEALTH TRUST

Business Health Trust Employee Enrollment / Change Form

Employer Name	Effective Date	Hire/Event Date	Reason For Enrollment
	/ /	/ /	☐ Hire/Rehire ☐ Loss of Coverage ☐ Birth/Adoption ☐ Open Enrollment ☐ COBRA/Extension ☐ Address/Name Change ☐ Add Dependants ☐ Delete Dependants ☐ Other ____________
Group #:		Hours per Week ______	☐ Termination Date of Termination___________

EMPLOYEE INFORMATION: PLEASE PRINT CLEARLY

First Name, Middle Initial, Last Name				Employee's Birth Date	Gender	Social Security #	
				/ /	☐ M ☐ F		
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' $15,000 basic life benefit.*	Underwritten by Regence BlueShield: ☐ Progressive $0 100/80/50 $25 ☐ Progressive $200 90/80/60 $20 ☐ Progressive $500 100/80/80/50 $25 ☐ HSA 1500 80/80/60 ☐ HSA 2500 80/80/60	Underwritten by Regence BlueShield: ☐ PPO Infinity $200 $25 ☐ PPO Infinity $500 $25 ☐ PPO Infinity $750 $25 ☐ PPO Infinity $1,000 $25 ☐ PPO Infinity $1500 $25	Underwritten by Regence BlueShield: ☐ PPO1 100/90/60/20 $200 ☐ PPO2 100/80/60/25 $300 ☐ Selections 100/70/20 ☐ Selections 80/50/20	Group Health Options, Inc. ☐ Alliant Plus Balance $100 ☐ Alliant Plus $20 Copay ☐ Alliant Plus, $500 plan ☐ Alliant Plus, $3000 50/50 plan
Prescription Drug Plans Underwritten by Regence BlueShield only.	☐ Plan $10/$20/$40 No deductible 2x mail ☐ Plan $10/$25/$50 No deductible 3x mail ☐ Plan $10/$20/$40 $50 brad deductible 2x mail (MAC A) ☐ Plan $10/$35/$70 $50 brand deductible 3x mail *RX Plan MUST BE TAKEN with RBS Medical. Separate RX Plan is NOT AVAILABLE with HSA Plan*			
Dental	Underwritten by Washington Dental Service (2 + Employees) ☐ Child Orthodontia Rider ☐ Family Orthodontia Rider ☐ Plan A ☐ Plan AA ☐ Plan C ☐ Plan F ☐ Plan G ☐ Plan GG ☐ Plan H ☐ Plan J			Underwritten by Dental Health Services 2 + Employee) ☐ SmartSmile ☐ Super SmartSmile
Basic Life and AD&D Underwritten by Regence Life and Health	☒$15,000 Life/AD&D included with all medical plans. ☐ $50,000 Life/AD&D ☐ 100% of annual salary to a $100,000 maximum ☐ 200% of annual salary to a $200,000 maximum 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			
Supplemental Life and AD&D Underwritten by Regence Life and Health	Increments of $10,000 to a maximum of $200,000 In no event shall the combined Basic and Supplemental benefits exceed $250,000. (Available if employer elects coverage) ☐ Amount_________________ Employer Group Size: 5- 49 = EE GI $25,000 Sp GI $10,000 Employer Group Size 50-99 = EE GI $50,000 Spouse GI $25,000			
Long Term Disability Underwritten by Regence Life and Health	☐Plan A 60%- $3K, 90EP ☐Plan B 60%- $3K, 180EP ☐Plan C 60%- $6K, 90EP ☐Plan D 60%- $6K, 180 EP (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.)			
Vision Underwritten by Vision Service Plan	☐ Vision Service Plan Signature Plan B (3 + Employees) ☐ Vision Service Plan Signature Choice		**Employee Assistance Plan**	☐ Wellspring Family Services (1 -3 Visit model)
Group Legal Plan	☐ 21st Century Legal Plan (Complete separate 21st Century Legal Plan form)		**Voluntary Personal Accident** Underwritten by AIG	☐ Provided by AIG (Complete separate AIG enrollment form)

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:	

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)	*Gender (Circle One)	Social Security #	Prior Coverage? ☐ Yes ☐ No *(if 'Yes' indicate Prior Coverage Below)* Primary Care Physician (PCP) Required for Selections Plans	Primary Care Physician (PCP) ID Number
Add/Delete	Self	/ /	Med Dent Vis	M F			
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			

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 for 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:

EMPLOYEE BENEFICIARY:	Primary Beneficiary Name and Relationship* for Basic Life/AD&D and Supplemental Life and/or AD&D	Primary Beneficiary Address
EMPLOYEE BENEFICIARY:	Contingent Beneficiary Name and Relationship** for Basic Life/AD&D and Supplemental Life and/or AD&D	Contingent Beneficiary Address

* 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.

▪ Regence BlueShield: 1800 Ninth Avenue PO Box 21267 Seattle, WA 98111-3267 ▪ Group Health Options, Inc.: 521 Wall Street PO Box 34750 Seattle, WA 98121-1536
▪ Washington Dental Service: 9706 4th Avenue NE Seattle, WA 98115 ▪ Regence Life and Health Insurance; PO Box 1271, MS E3A; Portland, OR 97207-1271 ▪
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
▪ AIG: 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 Regence BlueShield Web site at www.wa.regence.com or by phone at 1-800-458-3523 or 1-206-464-3663.

Employee Signature	Date	Employer Signature	Date