ENROLLMENT APPLICATION for Medical, Prescription, Vision & Dental Benefits
SEIU HEALTCARE NW HEALTH BENEFITS TRUST

PARTICIPATION RULES

To be eligible for this Plan, home care workers must work at least 86 hours per month for 3 consecutive months and allow an additional 2 month processing period. You will then be set up on the insurance with a carrier based upon your region and preference. If you sign up for a different health insurance plan while you are covered on this Plan, you must notify the Trust Administration Office immediately. This insurance is for home care workers only and does not cover family members or dependents.

If you have questions about this application form or benefits, call the Trust Administration Office (toll free)

Trust Administration Office: **Mail to:** PO Box 6 Mukilteo, WA 98275 - **Phone: (866) 371-3200** **FAX: (206) 859-2637**

Personal Information: ***Please print clearly and in English*** **(* indicates required information)**			
* Your Name: First Name		Middle Initial Last Name	
* Your Address:			State Zip
* Social Security Number:	* Date of Birth:	Day Phone: ( ) Cell Phone: ( )	* Gender: ☐ M ☐ F
* IP Provider Number (found on your State invoice):		Your Email Address (optional):	Preferred Language:

YOU CAN EITHER ENROLL OR WAIVE COVERAGE – ONLY COMPLETE THE SECTION BELOW THAT APPLIES TO YOU

☐ **WAIVER OF COVERAGE** (please provide a reason for your declining this coverage by checking applicable boxes below, then sign)

☐ Have coverage through another employer ☐ Have coverage through a family member ☐ Plan has no Dependent coverage
☐ Have WA Basic Health Plan ☐ Enrolled in Medicare ☐ Other _____

WAIVER OF COVERAGE ONLY: By signing below, I agree to waive my election of health insurance until the earlier of the next Open Enrollment opportunity or when I next experience a HIPAA special enrollment qualifying event

Signature (**this signature is for WAIVER OF COVERAGE ONLY**) **Date**

☐ **NEW ENROLLMENT**

Please complete below if you are enrolling in the Trust plan) Please note: You may enroll now even if you are not eligible at this time. When you become eligible, the Trust will notify you of your coverage effective date.

* **Medical:** Please place the insurance carrier choices below in the order of your preference. You will be enrolled based on your preference and the availability of that insurance choice in your zip code location. These insurance carrier choices are regional and not available in all parts of the state.

- **Group Health Cooperative** HMO
- **Kaiser Permanente** HMO
- **Regence Blue Shield** PPO

PLEASE WRITE IN YOUR ORDER OF INSURANCE CARRIER PREFERANCE

CHOICE #1 **CHOICE #2** **CHOICE #3**

* **Dental:** Please check one. ☐ **Premera Blue Cross Dental** **-or-** ☐ **Willamette Dental** HMO

NOTE: If you do not choose medical and dental carriers, the Trust will assign them for you.

Have you had other insurance in the last 12 months? ☐ Yes ☐ No If yes, please complete the fields below			
Current or Prior Coverage Information	Date Coverage Began:	Date Coverage Ended:	Name of Insurance Company:

If you had other health insurance in the last 12 months, please include a copy of your Certificate of Coverage. If you don't have one, you can request it from your prior insurance company. If you currently have other insurance and are enrolling in the Trust Plan, send the Certificate when your current plan ends.

APPLICATION AGREEMENT

I hereby apply for coverage under the contract between my health plan, and SEIU 775, and I agree with the terms of the contract. I certify that I meet all the eligibility criteria set forth in the outline of benefits and/or the contract. I have provided these answers as part of the application procedure required by the insurance carriers to enroll in coverage and I certify that all information completed on this form is true, correct, and complete. I understand that the insurance carriers 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 insurance carriers may result in the insurance carriers 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.

The information I have given in this application is true, correct and complete to the best of my knowledge. I understand that if I withhold information or give false or misleading information, I will lose coverage. If I have given false information, the Trust may prosecute me for perjury or bill me for ineligible services.

ENROLLMENT FOR COVERAGE ONLY: By signing below, I agree to the required monthly payroll deduction for my health insurance

Signature (**this signature is for ENROLLMENT FOR COVERAGE ONLY**) **Date**