TEAMSTERS

AWC EMPLOYEE BENEFIT TRUST

Combined Insurance Enrollment Form

Complete entire form to enroll or make changes.

Enrollment

- ❑ New hire
- ❑ New group
- ❑ Open enrollment

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.

EMPLOYEE #

SSN | Employee Name (last, first, initial) | Date of birth | Gender

❑ Single ❑ Married Date married: _____ ❑ Divorced Date divorced: _____

❑ Domestic partnership ❑ Partnership termination

Date met DP criteria: _____ Date terminated: _____

Home/mailing address | Phone (with area code)

City | State | Zip | Email address

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

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

Are you covered by any other insurance now? ❑ Yes ❑ No

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

Type of insurance requested: ❑ Medical ❑ Dental ❑ Life

Is spouse/domestic partner covered by any other insurance now? ❑ Yes ❑ No

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 # _____

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 will be requested, but not limited to, birth certificate, adoption papers. **Medical, dental** 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.

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 ❑ Life

Is dependent covered by any other insurance now? ❑ Yes ❑ No

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, 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, intitial)

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 ❑ Life

Is dependent covered by any other insurance now? ❑ Yes ❑ No

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, 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, intitial)

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

Employees: Employer will complete this section.
Send completed form to: **1076 Franklin Street SE, Olympia, WA 98501-1346**

Employer name	Date of hire	Effective date of change
CITY OF LYNNWOOD		

Employee's occupation	Weekly hours	Monthly base earnings	Dept. name	Online billing 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®
- ☐ High Deductable Health Plan

GroupHealth

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

☐ **Group Health Cooperative**
- ☐ $10 copay

Dental

DELTA DENTAL

Delta Dental of Washington

9706 Fourth Ave NE
Seattle, WA 98115

Delta Dental of Washington

- ☐ Plan F

Willamette Dental Group

6950 NE Campus Way
Hillsboro, OR 97124

Willamette Dental of Washington, Inc.
- ☐ $10 copay

Life

TheStandard® Positively different.

1100 SW 6th Ave
Portland, OR 97204

Standard Insurance Company

- ☐ Basic Life $ _____
- ☐ Accidental Death & Dismemberment
- ☐ Dependent Life
  - ☐ Plan option 1

Employee Assistance Program

ComPsych® — The GuidanceResources Company® —

NBC Tower
455 N. Cityfront Plaza Drive
Chicago, IL 60611-5322

ComPysch
- ☐ 1-3 sessions

Long-term Disability

TheStandard® Positively different.

1100 SW 6th Ave
Portland, OR 97204

Standard Insurance Company
- ☐ 90-day: 60% benefit