



Asuris Northwest Health  
 PO Box 91130  
 Seattle, Washington 98111-9230

## EMPLOYEE ENROLLMENT & CHANGE FORM

This Section For Asuris Northwest Health Use Only – RIQ Code: \_\_\_\_\_ Rel ICN# \_\_\_\_\_  
 ACRW Loaded: \_\_\_\_\_ COB Loaded: \_\_\_\_\_ Date Completed: \_\_\_\_\_ Auditor Initials \_\_\_\_\_

### EMPLOYEE SECTION:

Employee Legal Name: \_\_\_\_\_  
 Social Security #: \_\_\_\_\_ Phone #: \_\_\_\_\_  
 Residential Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Mailing Address, if different: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Employee Email Address: \_\_\_\_\_  
**Marital Status:**  Married  Single **Date of Marriage:** \_\_\_\_\_  
 Has Asuris Northwest Health assigned an alternate Identification number to you previously?  Yes  No. If yes, please provide if available: \_\_\_\_\_

**PLEASE COMPLETE ALL SECTIONS IN BLACK INK**  
**A Reason Must Be Checked for add, change or cancellation:**  
 Add Employee with/ without dependent(s)  Add Dependent(s) only  
**Add due to:**  
 New Group  Open Enrollment Changes  New Employee  
 Birth  Marriage  Adoption  COBRA coverage exhausted  
 Loss of eligibility on another coverage  
 Add DP – Domestic Partner and dependent(s)  
 (If employer allows DP coverage) (Must attach Domestic Partner Affidavit)  
 Add dependent(s) only, of DP – Domestic Partner  
 (If employer allows DP coverage) (Must attach Domestic Partner Affidavit)  
 Name Change  Address Change  
 Add to COBRA Effective Date: \_\_\_\_\_  
 Employee and dependent(s)  Dependent(s) Only  
 Add to 6-Month Extension Effective Date: \_\_\_\_\_  
 Employee and dependent(s)  Dependent(s) Only  
 Add to USERRA Extension Effective Date: \_\_\_\_\_

**CANCELLATIONS:**  
 (List names below)  
 Employee and dependent(s)  
 Dependent(s) Only  
 Intended Effective Date: \_\_\_\_\_  
 (Select cancel reason)  
 TE = Termination  
 RH = Reduction in Hours  
 DC = Dependent Child(ren)  
 DV = Divorced  
 DE = Death  
 DX = Disability Extension  
 MI = Medicare Ineligible  
 CE = Voluntary cancellation  
 of COBRA coverage  
 = Military Deployment

**Select Plan:**  
 PPO  
 HSA-Healthplan  
 Columbia Dental  
 Other \_\_\_\_\_

Medical/Dental (Indicate Selection) M D	Relationship	Name			Social Security Number or Individual Tax payor ID Number (ITIN)	Birth Date MM/DD/YYYY	Gender M/F
		Please note: our system only allows 19 characters, including spaces, for printing a name on a member card; therefore, longer names may show abbreviated on the card.					
		Last Name	First Name	Middle Initial			
<input type="checkbox"/>	<input type="checkbox"/>	Employee					
<input type="checkbox"/>	<input type="checkbox"/>	Spouse					
<input type="checkbox"/>	<input type="checkbox"/>	Child					
<input type="checkbox"/>	<input type="checkbox"/>	Child					
<input type="checkbox"/>	<input type="checkbox"/>	Child					

If any dependent child(ren) being added is/are covered under another plan and the natural parents are divorced or separated, Washington State regulations require that we ask the following:  
 Name of parent with custody (if parents have dual custody, indicate): \_\_\_\_\_  
 If divorced, did the court establish financial responsibility for the child(ren)'s healthcare?  Yes  No (Please provide a copy of the divorce decree maintenance agreement outlining coverage specifications.)  
 If YES, please specify the name and address of the parent with responsibility: \_\_\_\_\_

**Do you or any of your dependents applying for coverage have coverage (now, or within the past 6 months) with any health care plan?**  Yes  No  
**Will coverage remain in effect?**  Yes  No  
**IMPORTANT:** If you or any of your dependents applying for coverage have coverage (now, or within the past 6 months) with any health care plan, **you MUST complete the back of this form.**  
 Completing the information on the back of this form and/or attaching a certificate of coverage from the prior carrier, will allow Asuris to credit any applicable waiting periods for preexisting conditions and process claims quickly and accurately.

**EMPLOYEE RELEASE AND AUTHORIZATION:** *It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance. I hereby verify that all of the information specified above is accurate and complete. By signing below, I have authorized the release of information, for myself and my dependents listed above, to Asuris Northwest Health. (Spouse's signature required if Spouse is electing COBRA.)*

**EMPLOYEE SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_ **SPOUSE SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**EMPLOYER SECTION:** *The Employer section must be completed by the Group's Primary Contact Person as listed on the Group Master Application. If not fully completed, this form will be returned unprocessed.*  
 Group Name: \_\_\_\_\_ Group Number: \_\_\_\_\_ Group Phone Number: \_\_\_\_\_ Group E-mail Address: \_\_\_\_\_ Intended Effective Date: \_\_\_\_\_  
 Employee Class: \_\_\_\_\_ Work Location: \_\_\_\_\_ Date of Hire: \_\_\_\_\_ Rehire: \_\_\_\_\_ Date Changed from Part-time to Full-time: \_\_\_\_\_ Hours Worked Per Week: \_\_\_\_\_



# EMPLOYEE ENROLLMENT & CHANGE FORM

Please use black ink

## EMPLOYEE SECTION:

If you, the Employee, or any family members who are applying for coverage through Asuris Northwest Health currently have another health insurance coverage, or have had any other health insurance coverage within the past 6 (six) months before starting this coverage with Asuris Northwest Health, you should complete this section or if prior coverage has ended, attach a certificate of coverage from the prior insurance carrier. Other health insurance coverage includes another plan with Asuris Northwest Health, any other company, any Blue Shield or Blue Cross coverage, any retirement plan, or Medicare or Tricare. The information will be used to establish eligibility for credits on benefit waiting periods of pre-existing conditions and to coordinate with your other insurance carriers, to ensure that we pay your claims quickly and accurately. If you need to provide us with additional information about other coverage (prior coverage or current other coverage), please obtain Prior Coverage Information Request forms or Multiple Coverage Inquiry forms from our Web site at [www.asuris.com](http://www.asuris.com) or call our Customer Service department at 1-888-344-5587.

### PRIOR INSURANCE WITHIN THE PAST 6 MONTHS AND/OR CURRENT OTHER INSURANCE COVERAGE:

Prior or other Insurance Company Name: \_\_\_\_\_ Prior or other Insurance Company Phone #: \_\_\_\_\_

Prior or other Insurance Company Full Address: \_\_\_\_\_

Policyholder's Name: \_\_\_\_\_ Policyholder's Birth Date: \_\_\_\_\_ MMDDYYYY

Policyholder's Member ID # or Social Security #: \_\_\_\_\_ Group # or Policy ID #: \_\_\_\_\_ Effective Date of Other/Prior Coverage: \_\_\_\_\_

Will coverage remain in effect?  Yes  No Date coverage ended or will be ending: \_\_\_\_\_ Persons covered by prior or other insurance, please list names and birth dates:

Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_ MMDDYYYY Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_ MMDDYYYY

Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_ MMDDYYYY Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_ MMDDYYYY

Type of Coverage (please circle): Medical Pharmacy Dental Vision Medicare Type of Policy (please circle): Group Individual Medicaid Medicare Part A Medicare Part B Medicare Part D

Did your coverage include the following benefits (please circle): Chiropractic Maternity Prescription Drug Psychiatric Rehabilitation Transplants

If employee or dependents have Medicare, what was the begin date for Part A: \_\_\_\_\_ Part B: \_\_\_\_\_ Part D: \_\_\_\_\_ Medicare HIC# with Alpha Suffix: \_\_\_\_\_

Person covered by Medicare: Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_ Reason:  Disability  Over Age 65  End Stage Renal Disease

**YOUR SPECIAL ENROLLMENT PERIOD RIGHTS For individuals who are eligible for enrollment in a group health plan:** If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or 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 group health plan coverage, the employer stops contributing toward you or your dependents' other coverage.) However, you must request enrollment 30 days after your 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 31 days after the marriage, or within 60 days of birth, adoption, placement for adoption, or date of assumption of total or partial legal obligation for support of a child in anticipation of adoption. To request special enrollment or obtain more information, please contact your group administrator or benefits department.

#### APPLICATION AGREEMENT

For the protection of all of our members, fraud or misrepresentation of material fact by you and/or the Group for the purposes of defrauding Asuris Northwest Health may result in Asuris Northwest Health 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. In addition, Asuris Northwest Health will have the right to collect any claims payments or other damages.

I hereby apply for coverage under the contract between Asuris Northwest Health and my employer or group; and I agree with the terms of the contract. I have provided these answers as part of the application procedure required by Asuris Northwest Health to enroll in coverage and I certify that all information completed on this form is true, correct, and complete. I certify that my listed dependents and I meet the eligibility criteria set forth in the outline of benefits and/or the contract. I agree to pay in advance the appropriate rates for myself and listed dependents and authorize rate increases, as Asuris Northwest Health deems necessary.

#### RELEASE OF INFORMATION

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 our Web site at [www.asuris.com](http://www.asuris.com) or by phone at 1-888-344-5587.