

ENROLLMENT APPLICATION

Medical, Prescription Drugs, Vision & Dental Benefits



PARTICIPATION

To be eligible for this Plan, home care workers must work at least 86 hours per month for 3 consecutive months. Your coverage will begin once your enrollment is processed; it usually takes about 2 months. **If you currently have other health insurance, you must cancel that insurance when your new coverage starts.**

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 and does not cover family members or dependents. If you are eligible, your application will take about 2 months to process. The health insurance company will then mail you an insurance identification card and more information.

If you have questions about this application form or benefits, call the Member Resource Center (toll free)

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

Personal Information: Please print clearly and in English <input type="checkbox"/> Address Change <input type="checkbox"/> Name Change				
Your Name: First Name		Middle Initial	Last Name	
Your Address: Street		City	State	Zip
Required Information	Social Security Number	Date of Birth	Day Phone: ()	Gender <input type="checkbox"/> M <input type="checkbox"/> F
	IP Provider Number (found on your State invoice):		Cell Phone: ()	
Your Email Address (optional):			Preferred Language:	

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

NEW ENROLLMENT (complete the Dental Plan Choice and prior coverage section below, then sign and return to the Trust office)

Medical Plan: Based upon your zip code, you will be enrolled in either **Group Health Options** -or- **Kaiser Permanente**
Dental Plan Choice (check one): **Premera Blue Cross Dental** -or- **Willamette Dental HMO**

Have you had other insurance in the last 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> 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.			

ENROLLMENT FOR COVERAGE ONLY: 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. 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
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WAIVER OF COVERAGE ONLY (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	(DO NOT Sign Unless You Are DECLINING Coverage)	Date
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