ENROLLMENT APPLICATION

Medical, Prescription Drugs, Vision & Dental Benefits

SEIU 775 HEALTH BENEFITS TRUST

PARTICIPATION RULES

To be eligible for this Plan, home care workers must work at least 80 hours per month for 3 consecutive months.

Your coverage will begin once your enrollment application is processed; it typically takes 2 months after your application is received and after you have met your initial requirements of 80 hours for 3 consecutive months before your coverage will start.

This insurance does **not** cover family members or dependents.

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 Health Benefits Trust immediately at 1-866-771-7359.

Once your enrollment application is received we will mail you a letter confirming your application has been processed. If you do not receive a confirmation letter within 45 days of submitting this application, please contact the Health Benefits Trust at 1-866-771-7359.

QUESTIONS?

If you have questions about this form or benefits, call the Member Resource Center toll- free, at:

(866) 371-3200

PERSONAL INFORMATION

Please print clearly and in English

First Name	Middle Initial	Last Name

Street	Apt #	City	State	Zip

Social Security Number	Date of Birth (MM-DD-YY)	Day Phone: ( ) Cell Phone: ( )	Gender ☐ M ☐ F

IP Provider Number (found on your State invoice)	Email Address	Preferred Language

DENTAL PLAN CHOICE (CHECK ONE)

MEDICAL: Based on your ZIP code, your medical, vision and prescription drug coverage will be provided by Group Health or Kaiser Permanente.

DENTAL: The dental plan coverage choice is up to you. Choose a dental plan here:

PLEASE CHECK ONE.

☐ Delta Dental (Washington Dental Service) -or- ☐ Willamette Dental

1-800-554-1907 www.deltadentalwa.com

1-800-359-6019 www.willamettedental.com

TO APPLY:

Please send completed, signed application to the Health Benefits Trust. Please keep a copy for your records.

MAIL TO:
SEIU 775 Health Benefits Trust
PO Box 6, Mukilteo, WA 98275

FAX TO:
(206) 859-2637

EMAIL TO:
seiu@bsitpa.com

I hereby apply for enrollment as indicated on this application. I understand that the SEIU 775 Health Benefits Trust and the Insurers may collect, use and disclose protected health information about each individual enrolled under this application in order to carry out their routine business functions, including but not limited to, determining eligibility for benefits, paying claims, coordinating benefits with other insurance carriers or payer, underwriting and conducting case management care management and quality reviews. The SEIU 775 Health Benefits Trust and the Insurers may also disclose protected health information to state and federal agencies, or other third parties, as required by law. The undersigned understands that it is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purposes of defrauding the company. Penalties may include imprisonment, fines and denial of insurance benefits. By signing below, I agree to the required monthly payroll deduction for my health insurance. **In the event of an involuntary loss of HBT coverage, if minimum hour eligibility requirements are met again within 12 months from the date of coverage loss, coverage will be automatically reinstated.**

Signature _____ Date _____

Group Health Cooperative • 320 Westlake Ave. N., Ste. 100 • Seattle, WA 98109
Group Health Options • 320 Westlake Ave. N., Ste. 100 • Seattle, WA 98109
Kaiser Foundation Health Plan of NW • 500 NE Multnomah St., Ste. 100 • Portland, OR 97232

Washington Dental Service • PO Box 75688 NG Station • Seattle, WA 98175
Willamette Dental of Washington Inc • 6950 NE Campus Way • Hillsboro, OR 97124

SEIU 775
HEALTH BENEFITS TRUST

WAIVED COVERAGE REQUEST FORM

Please check the appropriate box, sign and date the bottom of the form and return.

☐ I do not wish to enroll at this time as I currently have coverage elsewhere.

By signing this form, you confirm that you are declining to participate in the SEIU 775 Health Benefits Trust insurance plan. If you are already covered under SEIU 775 Health Benefits Trust, this form will NOT terminate your benefits. See your medical plan booklet or SEIU 775 Health Benefits Trust for more details.

Signature _____ Name _____

Provider Number _____ Date _____