

Employee Signature:

Employee Enrollment Application

Administered by: Zenith American Solutions Address: 11724 NE 195th Street, Suite 300 Bothell, WA 98011-3145 (866)770-1917 Agency Name: Branch: Address: City: State: Zip: Address Change Dep Change Special Enrollment (see below) Check One Open Enrollment New Employee Reinstatement Name Change Check One if enrolling for Special Marriage/Domestic Partnership Involuntary Loss of Coverage Birth Court Order/Adoption/Legal Guardianship **Enrollment** (Documents May be Required): PERSONALINFORMATION: Please Print Clearly and in English **Employee** Name: Social Security Number First MI Date of Birth Last State: Zip: Address: City: Marital Status: F Phone: Date of Marriage/Divorce: Gender: M Your Email Address (Optional): Primary Language: Admin Staff Delta Dental of Washington Medical Kaiser Foundation Health Plan of Dental Kaiser Foundation Health Plan of Washington or the Northwest Field Worker Willamette Dental of Washington Inc. Kaiser Foundation Health Plan of Washington Options, Inc. Coverage: Coverage: **Employees Prior** Previous Carrier: Date Prior Coverage Began Date Prior Coverage Ended **Coverage Information:** ĪР SEIU Trust Coverage: Agency or DEPENDENT ENROLLMENT INFORMATION: PRIOR COVERAGE INFORMATION: Add or Previous Date Prior Date Prior Relationship Date of SSN First Name ΜI Last Name Gender to Employee Birth Delete Carrier Coverage Began Coverage Ended I hereby apply for enrollment or change of enrollment as indicated on this application. I understand that the SEIU 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 Healthcare NW 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.

Employee eligibility will not be forwarded without employee signature. Please return this form to your Agency.

Date Signed: