SEIU HEALTHCARE NW
HEALTH BENEFITS TRUST

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:**	
Check One	☐ Open Enrollment	☐ New Employee	☐ Reinstatement	☐ Address Change	☐ Name Change	☐ Dep Change	☐ Special Enrollment (see below)
Check One if enrolling for Special Enrollment *(Documents May be Required)*:	☐ Marriage/Domestic Partnership	☐ Involuntary Loss of Coverage	☐ Birth	☐ Court Order/Adoption/Legal Guardianship			

PERSONAL INFORMATION: **Please Print Clearly and in English**

Employee Name:					
	Last	First	MI	Social Security Number	Date of Birth
Address:		City:		State:	Zip:
Phone:		Marital Status:		Date of Marriage/Divorce:	Gender: M F
Your Email Address (Optional):			Primary Language:		

Medical Coverage: Kaiser Foundation Health Plan of Washington or Kaiser Foundation Health Plan of Washington Options, Inc. — Kaiser Foundation Health Plan of the Northwest — ☐ Admin Staff ☐ Field Worker

Dental Coverage: ☐ Delta Dental of Washington ☐ Willamette Dental of Washington Inc.

Employees Prior Coverage Information:	Previous Carrier:		Date Prior Coverage Began	Date Prior Coverage Ended
	SEIU Trust Coverage:	☐ Agency *or* ☐ IP		

DEPENDENT ENROLLMENT INFORMATION:								**PRIOR COVERAGE INFORMATION:**		
Relationship to Employee	Last Name	First Name	MI	Gender	Date of Birth	SSN	Add or Delete	Previous Carrier	Date Prior Coverage Began	Date Prior Coverage Ended

I hereby apply for enrollment or change of enrollment as indicated on this application. I understand that the SEIU Healthcare NW 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 Signature: **Date Signed:**

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