SEIU 775 BENEFITS GROUP

Dependent Enrollment Application

Administered by: Zenith American Solutions Inc. 11724 NE 195th Street, Suite 300 | Bothell, WA 98011-3145 | Phone: 1 (866) 770-1917

Home Care Aide Information

Your Full Name	Social Security Number

If you enroll your dependent in coverage, you have to pay the full premium through automatic payroll deduction. Full premiums range from $653-$790 per dependent per month. If you would like more information about the price of dependent coverage please call the Member Resource Center (MRC) at 1-866-371-3200.

Dependent Enrollment Information

Use additional forms to list additional dependents. **Please print clearly.**
Please provide the Social Security Number of each dependent you enroll.
Federal regulations require health plans to report the names, and Social Security Numbers of every covered individual to the IRS.

1. Name (Last, First, Middle Initial)	Relationship to Employee	Gender
	☐ Child	☐ Male ☐ Female

Social Security Number	Date of Birth (mm/dd/yyyy)	Medical / Dental

2. Name (Last, First, Middle Initial)	Relationship to Employee	Gender
	☐ Child	☐ Male ☐ Female

Social Security Number	Date of Birth (mm/dd/yyyy)	Medical / Dental

VERY IMPORTANT: YOU MUST READ AND SIGN THIS FORM FOR COVERAGE TO TAKE EFFECT

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 beneftis 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 inusrance 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. I understand if my hours drop below 80 through my primary employer, HBT may combine my hours from other home care agencies or the state to meet the 80 hour requirement and keep me enrolled in my health plan.

APPLICATION DUE DATE: The 15th of every month.

Please return your completed and signed form to the Health Benefits Trust.

Mail to: Zenith American Solutions, Inc.
11724 NE 195th Street, Suite 300 Bothell, WA 98011-3145
Fax to: (206) 298-3424
Email to: SEIU-HBT@zenith-american.com

Employee Signature _____ Date _____

Employee Name (please print) _____