SEIU 775 BENEFITS GROUP

Home Care Aide Enrollment Application

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

APPLICATION FOR AN INDIVIDUAL TO ENROLL IN THE SEIU BENEFITS GROUP PLAN

- **This is an application, not a guarantee of enrollment for coverage.**
- If you are an Agency Provider and you want to enroll a dependent, please refer to the Dependent Enrollment Application.
- If you are already enrolled, but want to change your dental plan, please refer to our Dental Change Form.

APPLICATION DUE DATE (For Agency Providers only): The 15th of every month, for coverage the following month.

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 1-866-770-1917.

QUESTIONS?

If you have questions about this form or benefits, call the Member Resource Center toll free at: 1-866-770-1917.

1. EMPLOYER INFORMATION (Agency Providers Only)

Employer Name | Branch (APs only)

Address

City | State | Zip

IPOne # - (IPs only)

2. COMPLETE SECTIONS 2 AND 3 AND SIGN THIS FORM

Last Name | First Name | Middle Initial

Social Security Number | ☐ Male ☐ Female | Date of Birth Month Day Year

Home Mailing Address

City | State | Zip

Phone Number
Home: ( ) Work: ( )

Email

3. MEDICAL AND DENTAL PLANS

Medical: Plan assigned by Zip Code

Dental: Select your preferred plan below

☐ Delta Dental of Washington ☐ Willamette Dental Group

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, for coverage the following 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)