SEIU 775 BENEFITS GROUP

Dependent Enrollment Application

Administered by MagnaCare
PO BOX 24811, Seattle WA 98124

Phone: 877-606-6705
Fax: 516-723-7395
Email: SEIU775BG-caregiver@magnacare.com

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 $666-$766 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, MI):	Relationship to Employee:	Gender:
		☐ Male ☐ Female

Social Security Number:	Date of Birth (MM/DD/YY):	Medical / Dental

2. Name (Last, First, MI):	Relationship to Employee:	Gender:
		☐ Male ☐ Female

Social Security Number:	Date of Birth (MM/DD/YY):	Medical / Dental

3. Name (Last, First, MI):	Relationship to Employee:	Gender:
		☐ Male ☐ Female

Social Security Number:	Date of Birth (MM/DD/YY):	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 in SEIU 775 Benefits Group health insurance as indicated on this application. I understand that the SEIU Healthcare NW Health Benefits Trust and the Network Provider 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 payers, underwriting and conducting case management, care management and quality reviews. The SEIU Healthcare NW Health Benefits Trust and the Network Provider 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 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: MagnaCare
PO BOX 24811, Seattle WA 98124
Fax: 516-723-7395
Email: SEIU775BG-caregiver@magnacare.com

Employee Signature **Date Signed**

Employee Name (please print)