SEIU 775 BENEFITS GROUP

Health Benefits Application

For Caregivers Not Already Enrolled in Coverage

Administered by MagnaCare

MagnaCare PO BOX 24811, Seattle WA 98124 | Phone: 1 (877) 606-6705

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 already enrolled, but want to change your dental plan, please refer to our Dental Change Form.
- If you are an Agency Provider and you want to enroll a dependent, please refer to the Dependent Enrollment Application.

APPLICATION DUE DATE: 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 SEIU 775 Benefits Group at 1 (866) 371-3200.

SAVE TIME AND EFFORT! Apply for benefits online at www.myplanbg.org.
QUESTIONS? If you have questions about this form or benefits, call the MRC toll free at: 1 (866) 371-3200.

1. HOME EMPLOYER* INFORMATION

Employer Name:		**Agency Branch (APs Only):**	
Address:	**City:**	**State:**	**Zip:**
IPOne # - (IPs Only)			

*This is the employer who will deduct your $25 monthly co-premium from your paycheck. Your home employer may be reassigned in the future to a secondary employer, based on your number of monthly hours worked.

2. COMPLETE SECTIONS 2 AND 3 AND SIGN THIS FORM

First Name:	**MI:**	**Last Name:**	
Social Security Number:	**Gender:** ☐ Male ☐ Female	**Date of Birth:**	
Address:	**City:**	**State:**	**Zip:**
Phone (Home):	**(Work):**	**Email Address:**	

3. MEDICAL AND DENTAL PLANS

Medical: Plan assigned by zip code	Kaiser Permanente Northwest	
Dental: Select your preferred plan	☐ Delta Dental	☐ 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 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 Providers 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 Providers 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 SEIU 775 Benefits Group.

Mail to: MagnaCare PO BOX 24811, Seattle WA 98124
Fax to: (516) 723-7395
Email to: SEIU775BG-caregiver@magnacare.com

Employee Signature **Date Signed**

Employee Name (please print)