GREATER NORTHWEST Health Industry BENEFITS TRUST

Employee Enrollment & Change Form 2019

Medical Group Number:

1. GROUP INFORMATION (to be completed by the group) Please Be Sure To Fill Out All Sections

Group Name:	Effective Date: _____ Date of Hire: _____	Rate of Pay and Amount: $ _____ per ☐ Yr ☐ Mo ☐ Bi-Wk ☐ Wk ☐ Hr Hours worked per week _____

☐ **New** ☐ **Change (Mark Reason Below) COBRA carry-over election must use COBRA carryover application to enroll**

☐ Hire/Rehire ☐ Open Enrollment ☐ Loss of Prior Coverage ☐ Address/Name Change ☐ Add or ☐ Remove Dependent(s)

Effective Date of Change: _____ Reason _____

☐ **Termination:** Last day Worked _____ Last day Compensated _____ Date Coverage Ends _____

☐Voluntary ☐Involuntary of Coverage

2. EMPLOYEE INFORMATION (employee to complete sections 2 through 5) Please print legibly and sign Application

Employee Name: (Last, First, MI)	**Social Security #:** - -	**Date of Birth**:	☐ Male ☐ Female ☐ Married ☐ Unmarried	Home Phone: ( ) -	Worksite Location (State):
Mailing Address: City State Zip				Employee Email Address:	

3. ENROLLMENT INFORMATION: Please note that an incomplete application will delay processing. Please make sure to print legibly and sign application. By providing your email address, you are agreeing to receive plan documents via electronic delivery.

☐ I choose to **WAIVE** Medical/Rx coverage due to Medicare Supplement, but elect any ancillary coverage chosen by my employer (i.e. dental, vision). Basic Life not available.

☐ I choose to **WAIVE** the Medical/Rx coverage for myself and my dependents. **Reason for Waiving:** _____

☐ I choose to **WAIVE** dental coverage.

☐ I choose to **WAIVE** vision coverage.

Medical Plan Choice (Underwritten by Asuris Northwest Health):

☐ I choose to **ELECT** medical coverage. Plan Selection: _____(Your employer has selected the options available to you. See your benefit administrator for details. Compulsory $15,000 Life/AD&D is included with all medical. Beneficiary is required. See Section 4.)

Dental Plan Choice (Underwritten by Delta Dental of Washington): Only available if chosen by your employer.

☐ I choose to **ELECT** dental coverage. Plan Selection: _____(Your employer has selected the options available to you. See your benefit administrator for details.)

Vision Plan Choice (Underwritten by VSP, Vision Care Inc.): Only available if chosen by your employer.

☐ I choose to **ELECT** vision coverage. Plan Selection: _____(Your employer has selected the options available to you. See your benefit administrator for details.)

Supplemental Employee and Dependent Life and AD&D Underwritten by Standard Insurance Company (Only available if chosen by your employer) Supplemental Employee Life/AD&D coverage. ☐ Yes ☐ No

If "YES" for Employee Coverage: Supplemental Dependent Life/AD&D for Spouse Only ☐ Yes ☐ No

Supplemental Life for Dependent Child(ren) ☐ Yes ☐ No

Amount of Coverage Requested (Please see your benefit administrator for allowed increments) Employee:_____Spouse: _____

NOTE: In order for dependents to qualify for a benefit selection, the employee must select the same benefit. Please indicate each member's name as you would like it to appear on the ID Card. ID cards are limited to 26 characters and spaces. If dependent has separate mailing address, please attach.

Add	Drop	Relationship	Last Name	First Name	MI	Social Security No.	Date of Birth	Gender		Benefit Selection		
								M	F	Med	Dent	Vis
☐	☐	Spouse ☐ Domestic Partner ☐*				- -		☐	☐	☐	☐	☐
☐	☐					- -		☐	☐	☐	☐	☐
☐	☐					- -		☐	☐	☐	☐	☐
☐	☐					- -		☐	☐	☐	☐	☐
☐	☐					- -		☐	☐	☐	☐	☐
☐	☐					- -		☐	☐	☐	☐	☐

For individuals who are eligible for enrollment in an employer group health plan: If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or employer group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if, in the case of employer group health plan coverage, the employer stops contributing toward you or your dependents' other coverage.) However, **the request for enrollment should be received by AIMS within 60 Days after you or your dependents' other coverage ends** (or after the employer stops contributing toward the other coverage). In addition, if you gain a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, we encourage enrollment within 60 days after the marriage, birth, adoption or assumption of a legal obligation for total or partial support of the child in anticipation of adoption. *Non-registered Domestic Partners must submit an Affidavit of Qualifying Domestic Partnership. Proof of registration is not required for state-registered domestic partners when an enrollment form is submitted, however Membership may ask for proof during the course of a standard audit.

4. DESIGNATION OF BENEFICIARY – Mandatory to complete for designation of benefit provided with ALL Life Products, including the $15,000 Life Policy included with your Medical Coverage

EMPLOYEE BENEFICIARY:	Primary Beneficiary **Name and Relationship*** for Basic life/AD&D & Supp. Life/AD&D	Primary Beneficiary Address
EMPLOYEE BENEFICIARY:	Contingent Beneficiary **Name and Relationship**** for Basic life/AD&D & Supp. Life/AD&D	Contingent Beneficiary Address

*** If more than one primary beneficiary is named, the primary beneficiaries shall share equally unless otherwise indicated above.**
**** Contingent Beneficiary(ies) will only receive proceeds if all Primary Beneficiaries have predeceased the Insured. If you are naming more than one Contingent Beneficiary at 100% each, please indicate them in order of precedence.**

5. SIGNATURE

I hereby apply for enrollment or change of enrollment as indicated on this application. I understand that the Trust and the Health Carriers or 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 Trust and the Health Carriers and Insurers may also disclose protected health information to state and federal agencies, or other third parties, as required by law. I understand that information collected in connection with administration of the benefit plan may be used to bring to my attention health products or services that might be valuable to me and otherwise as permitted by law. **I agree to accept and/or access all plan documents and notices via electronic delivery. This does not include documents sent directly from the Health Carrier. My consent can be withdrawn at any time, without charge. In order to withdraw or obtain a paper version of any document or notice, I will send a written request to AIMS, at the address listed below.**

I understand that the health benefit plan that I have selected provides reimbursement for certain medical costs, which are more fully described in the current Certificate of Coverage. I understand there may be instances where treatment decisions made by my physician or me or medical expenses which I have incurred may not be covered by my health benefit plan.
The undersigned understands that it is a crime to knowingly provide false, incomplete, or misleading information to a health carrier or insurance company for the purposes of defrauding the company. Penalties include imprisonment, fines and denial of health coverage or other insurance benefits. The changes on this form supersede all previous forms submitted. I authorize my employer to deduct from my earnings the amount, if any, for the coverage selected. **Please note: Incomplete applications will delay processing.**

Employee Signature (required) Date:	**Employer Signature (required)** Date:
HSA members have the option of selecting whether or not they would like to authorize claims integration with HealthEquity. The option to opt-in or opt-out will be administered through the application process, by calling customer service or available through the member preferences section of the member dashboard under "My account" through Asuris.com.	**Please return form to:** **AIMS** **1206 North Lincoln, Suite 200** **Spokane, WA 99201-2559** fax to: (509) 777-2690 or email to **aims@aiin.com**

Asuris Northwest Health 1800 Ninth Avenue Seattle, WA 98101	Standard Insurance Company 920 SW 6th Avenue Portland, OR 97204	Delta Dental of Washington 400 Fairview Ave N #800 Seattle, WA 98109	VSP, Vision Care Inc. 3333 Quality Dr. Rancho Cordova, CA 9567	Magellan Health Services 14100 Magellan Plaza Drive MO-10 Maryland Heights, MO 63043

DISCRIMINATION IS AGAINST THE LAW
Asuris complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Asuris does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Asuris:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
    - Qualified sign language interpreters
    - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
    - Qualified interpreters
    - Information written in other languages

If you need these services, contact us at 888-232-8229.

If you believe that Asuris has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our civil rights coordinator at M/S CS B32B, P.O. Box 1271, Portland, OR 97207-1271, phone: 888-232-8229, TTY: 711,
email: CS@Asuris.com. Please indicate you wish to file a civil rights grievance. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance our Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

HELP IN OTHER LANGUAGES
The following translations help people who do not read English understand their rights and responsibilities and who to call for help. Including these translations is a federal requirement for all health plans sold on the state or federal marketplaces.

Spanish: Este aviso tiene información importante. Asuris cumple con las leyes de derechos civiles federales aplicables y no discrimina sobre la base de raza, color, nacionalidad, edad, discapacidad o sexo. Este aviso tiene información importante sobre su solicitud o cobertura. Busque las fechas importantes en este aviso. Es posible que tenga que tomar alguna acción en un determinado plazo para mantener su cobertura de salud o ayuda con los costos. Usted tiene derecho a obtener esta información y otra información sobre su solicitud o cobertura, en su propio idioma y sin costo. Llame al 888-232-8229. (TTY: 711)

Chinese Traditional: 本通知含有重要資訊。Asuris
遵守適用之聯邦政府民權法，不會因種族、膚色、原始出生國籍、年齡、身心障礙或性別的不同而予以差別待遇。本通知含有有關您申請或進行承保的重要資訊。請留意本通知內的重要日期。請在期限之前採取行動，以確保您的醫療保障或協助支付費用。您有權索取使用您語言撰寫的這類資訊，以及有關您申請或承保的相關資訊。請撥打 888-232-8229 索取。（聽障專線：711）

Vietnamese: Thông báo này có Thông tin Quan trọng. Asuris tuân thủ luật pháp Liên bang về quyền công dân hiện hành và không phân biệt đối xử theo chủng tộc, màu da, nguồn gốc quốc gia, độ tuổi, khuyết tật hoặc giới tính. Thông báo này có thông tin quan trọng về đơn đăng ký hoặc bảo hiểm của quý vị. Tìm những ngày chính trong thông báo này. Quý vị có thể cần hành động trước một số thời hạn để duy trì bảo hiểm sức khỏe của mình hoặc được giúp đỡ có tính phí. Quý vị có quyền lấy thông tin này và thông tin khác về đơn đăng ký hoặc bảo hiểm, bằng ngôn ngữ của mình miễn phí. Gọi số 888-232-8229. (TTY: 711)

Korean: 이 공지 사항에는 중요 정보가 들어 있습니다. Asuris은 해당 연방 민권법을 준수하며 인종, 피부색, 출신 국가, 연령, 장애, 또는 성별에 따라 차별하지 않습니다. 이 공지 사항에는 해당 신청서 또는 적용 범위에 관한 중요한 정보가 있습니다. 이 공지 사항의 주요 날짜를 찾아 보십시오. 해당 건강 보험을 그대로 유지하거나 비용을 지원 받으려면 특정 기한까지 조치를 취하셔야 합니다. 귀하는 모국어로 작성된 본 정보나 해당 신청서 또는 보장 범위에 대한 기타 정보를 무료로 받을 수 있는 권리가 있습니다. 888-232-8229로 연락하십시오. (TTY: 711)

Russian: В данном Уведомлении содержится важная информация. Asuris несет обязательства по соблюдению применимых норм федерального законодательства о гражданских правах и не допускает дискриминации по признаку расы, цвета кожи, национального происхождения, возраста, статуса инвалидности или пола. В данном уведомлении содержится важная информация о вашем заявлении или страховом покрытии. Обратите внимание на ключевые даты, указанные в данном уведомлении. Возможно, вам нужно предпринять некоторые действия к определенному сроку, чтоб сохранить страховое покрытие или получить помощь с расходами. Вы имеете право получить данную, а также прочую информацию о вашем заявлении или страховом покрытии на родном языке бесплатно. Позвоните по номеру 888-232-8229. (TTY: 711)

Tagalog: Ang Abiso na ito ay may Mahalagang Impormasyon. Ang Asuris ay sumusunod sa mga naaangkop na Pederal na batas sa mga karapatang sibil at hindi nagdidiskrimina batay sa lahi, kulay, bansang pinagmulan, edad, kapansanan, o kasarian. Ang abiso na ito ay may mahalagang impormasyon tungkol sa iyong aplikasyon o coverage. Hanapin ang mga importanteng petsa sa abiso na ito. Maaaring kailangan mong gumawa ng hakbang hanggang sa mga partikular na takdang araw upang mapanatili mo ang iyong coverage sa kalusugan o tulong sa mga gastusin. May karapatan kang makuha ang impormasyong ito, at iba pang impormasyon tungkol sa iyong aplikasyon o coverage, sa iyong sariling wika nang walang bayad. Tumawag sa 888-232-8229. (TTY: 711)

Ukrainian: Це повідомлення містить важливу інформацію. Asuris дотримується застосовного федерального законодавства про громадянські права та не проводить політику дискримінації за расовою приналежністю, кольором шкіри, походженням, віком, інвалідністю та статевою ознакою. Це повідомлення містить важливу інформацію про пов’язану з вами програму або страхове покриття. Зверніть увагу на ключові дати в цьому повідомленні. Щоб зберегти за собою план медичного страхування або право отримувати грошову допомогу, можливо, вам потрібно буде вжити відповідні заходи, для яких установлено певні часові обмеження. Ви маєте право на безкоштовне отримання рідною мовою як цієї інформації, так і будь-якої іншої, пов’язаної з програмою чи страховим покриттям. Телефонуйте за таким номером: 888-232-8229 (телетайп: 711).

Mon-Khmer, Cambodian: សេចក្តីជូនដំណឹងនេះមានព័ត៌មានសំខាន់ ។ Asuris អនុលោមទៅតាមច្បាប់របស់សហព័ន្ធស្តីពីសិទ្ធិពលរដ្ឋ
ហើយមិនមានការរើសអើងចំពោះពូជសាសន៍ ពណ៌សម្បុរ សញ្ជាតិដើម អាយុ ពិការភាព ឬភេទឡើយ ។ សេចក្តីជូនដំណឹងនេះមានព័ត៌មានសំខាន់ស្តីអំពីពាក្យសុំ
ឬការធានារ៉ាប់រងសុខភាពរបស់អ្នក ។ សូមរកមើលកាលបរិច្ឆេទសំខាន់ៗក្នុងសេចក្តី ជូនដំណឹងនេះ ។
អ្នកអាចត្រូវចាត់វិធានការឲ្យបានត្រឹមកាលបរិច្ឆេទកំណត់ ដើម្បីរក្សាបាននូវការធានារ៉ាប់រងសុខភាព
ឬបានទទួលការជួយចេញការចំណាយថ្លៃថែទាំសុខភាពរបស់អ្នក ។ អ្នកមានសិទ្ធិទទួលបានព័ត៌មាននេះ និងព័ត៌មានដទៃ អំពីពាក្យសុំ
ឬការធានារ៉ាប់រងសុខភាពរបស់អ្នក ជាភាសាដែលអ្នកប្រើ ដោយមិនបាច់បង់ប្រាក់ឡើយ ។ ហៅមកលេខ 888-232-8229 ។ (អ្នកពិបាកស្តាប់
ឬពិបាកនិយាយដែលប្រើ TTY សូមហៅមកលេខ ៖ 711)

Japanese: このお知らせには大変重要な情報が含まれています。 Asuris
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Amharic: ይህ ማሳሰቢያ ጠቃሚ መረጃ ይዟል። Asuris በሚተገበረው የፌደራል ሲቪል መብቶች ህግጋት በዘር፣ በቀለም፣ በመጡበት ብሄር፣ እድሜ፣ የአካል ጉዳት ወይም ፆታ መድሎ አይደረግም። ማሳሰቢያው ስለ ማመልከቻዎትና ሽፋን ጠቃሚ መረጃ አለው። በዚህ ማሳሰቢያ ላይ ቁልፍ ቀናትን ይፈልጉ። በተወሰኑ የመጨረሻ ቀናት የጤና ሽፋኑ ላይ ወይም የወጪን ድጋፍ እንዲቀጥል እረምጃ መውሰድ ያስፈልጋል። ይህንን መረጃ እንዲሁም በማመልከቻዎት ወይም ሽፋኑ ላይ ሌሎችንም መረጃዎች በራስዎን ቋንቋ ያለምንም ክፍያ የማግኘት መብት አሎት። 888-232-8229 ይደውሉ። (ቲቲዋይ፡- 711)

Cushite/Oromo: Beeksisni kun odeeffannoo barbaachisaa qabatee jira. Asuris Ulaagaa seera mirga Siivilii Federaalaa kan guutuu fi sanyii, bifa, lammummaa, umrii, miidhama qaamaa ykn saala irratti hundaa’ee addaan hinqoodne dha. Beeksisni kun iyyannoo ykn haguuggii kara keessan irratti odeeffannoo barbaachisaa qabatee jira. Guyyoota furtuu beeksisa kana keessa jiran ilaalaa. Haguuggii fayyaa ykn gargaarsa keessan eeggachuuf hanga dhuma yeroo ta’eetti tarkanfii ta’e gatii bastanii fudhachuu qabdu. Odeeffannoo kana fi waa’ee iyyannoo ykn haguuggii keessanii kaffaltii tokko malee afaan keessaniin argachuuf mirga qabdu. Bilbilaa 888-232-8229. (TTY: 711)

Arabic:

يحتوي هذا الإخطار على معلومات مهمة. تمتثل Asuris إلى قوانين الحقوق المدنية الفيدرالية المعمول بها ولا تمارس التمييز على أساس العرق أو اللون أو الأصل القومي أو السن أو الإعاقة أو الجنس. يحتوي هذا الإخطار على معلومات مهمة عن الطلب أو التغطية الخاصة بك. ابحث عن التواريخ الرئيسية في هذا الإخطار. فقد تحتاج إلى اتخاذ إجراء ما قبل بعض المواعيد النهائية للحفاظ على التغطية الصحية الخاصة بك أو تلقي مساعدة بخصوص التكاليف. لديك الحق في الحصول على هذه المعلومات والمعلومات الأخرى المتعلقة بالطلب أو التغطية الخاصة بك بلغتك مجانًا. اتصل بالرقم 888-232-8229. (الكتابة عن بُعد للصم: 711)

Punjabi: ਇਸ ਨੋਟਿਸ ਵਿੱਚ ਮਹੱਤਵਪੂਰਨ ਜਾਣਕਾਰੀ ਹੈ। Asuris ਲਾਗੂ ਫੈਡਰਲ ਨਾਗਰਿਕ ਅਧਿਕਾਰਾਂ ਦੇ ਕਨੂੰਨ ਦੇ ਅਨੁਰੂਪ ਹੈ ਅਤੇ ਜਾਤਿ, ਰੰਗ, ਰਾਸ਼ਟਰੀ ਮੂਲ, ਉਮਰ, ਅਪਾਹਿਜਤਾ, ਜਾਂ ਲਿੰਗ ਦੇ ਅਧਾਰ 'ਤੇ ਭੇਦਭਾਵ ਨਹੀਂ ਕਰਦਾ। ਇਸ ਨੋਟਿਸ ਵਿੱਚ ਤੁਹਾਡੇ ਬੇਨਤੀ-ਪੱਤਰ ਅਤੇ ਸੁਰੱਖਿਆ ਬਾਰੇ ਮਹੱਤਵਪੂਰਨ ਜਾਣਕਾਰੀ ਹੈ। ਇਸ ਨੋਟਿਸ ਵਿੱਚ ਮੁੱਖ ਮਿਤੀਆਂ ਵੇਖੋ। ਤੁਹਾਨੂੰ ਤੁਹਾਡੀ ਸਿਹਤ ਸੁਰੱਖਿਆ ਰੱਖਣ ਜਾਂ ਲਾਗਤਾਂ ਨਾਲ ਮਦਦ ਕਰਨ ਲਈ ਨਿਯਤ ਮਿਆਦ ਸੀਮਾਵਾਂ ਦੁਆਰਾ ਕਾਰਵਾਈ ਕਰਨ ਦੀ ਲੋੜ ਹੋ ਸਕਦੀ ਹੈ। ਤੁਹਾਨੂੰ ਇਹ ਜਾਣਕਾਰੀ, ਅਤੇ ਆਪਣੇ ਬੇਨਤੀ ਪੱਤਰ ਜਾਂ ਸੁਰੱਖਿਆ ਬਾਰੇ ਹੋਰ ਜਾਣਕਾਰੀ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਬਿਨਾ ਕਿਸੇ ਲਾਗਤ ਤੋਂ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੈ। 888-232-8229 'ਤੇ ਕਾਲ ਕਰੋ। (TTY: 711)

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Laotian: ແຈ້ງການສະບັບນີ້ ມີຂໍ້ມູນທີ່ສຳຄັນ. Asuris ສອດຄ່ອງກັບກົດໝາຍ ວ່າດ້ວຍ ສິດທິພົນລະເມືອງຂອງຣັຖບານກາງ ທີ່ກ່ຽວຂ້ອງ ແລະ ບໍ່ມີການຈຳແນກ ເຊື້ອຊາດ, ສີຜິວ, ຊາດກຳເນີດ, ອາຍຸ, ຄວາມບົກພ່ອງ ຫຼື ເພດ. ແຈ້ງການສະບັບນີ້ ມີຂໍ້ມູນທີ່ສຳຄັນກ່ຽວກັບການນຳໃຊ້ຂອງທ່ານ ຫຼື ການຄຸ້ມຄອງ. ຊອກຫາວັນທີທີ່ສຳຄັນໃນແຈ້ງການສະບັບນີ້. ທ່ານອາດຈະຕ້ອງການດຳເນີນການໃນຂອບເຂດເວລາໃດໜຶ່ງ ເພື່ອ ໃຫ້ສືບຕໍ່ໄດ້ຮັບການຄຸ້ມຄອງສຸຂະພາບຂອງທ່ານ ຫຼື ການຊ່ວຍເຫຼືອທາງດ້ານງົບປະມານ. ທ່ານມີສິດເອົາຂໍ້ມູນນີ້ ແລະ ຂໍ້ມູນອື່ນ ກ່ຽວກັບການສະໜັກ ຫຼື ການຄຸ້ມຄອງຂອງທ່ານ ທີ່ເປັນພາສາຂອງທ່ານໂດຍບໍ່ເສຍຄ່າໃຊ້ຈ່າຍ. ຕິດຕໍ່ 888-232-8229. (TTY: 711)