



12401 E. Marginal S., Tukwila, WA 98168  
P.O. Box 34750, Seattle, WA 98124-9745

# Employee Enrollment and Change Form

## EMPLOYER: PLEASE COMPLETE THIS SECTION

Coverage Effective Date _____	Original Date of Hire ____/____/____	<b>Choose one:</b> <input type="checkbox"/> Open Enrollment <input type="checkbox"/> New Employee <input type="checkbox"/> Address/Name Change <input type="checkbox"/> Add Dependent(s) <input type="checkbox"/> Remove Coverage ____ Subscriber    ____ Dependent(s) Date Processed _____ By _____	<input type="checkbox"/> <b>Transfer to COBRA</b> Start Date _____ <input type="checkbox"/> 18 months <input type="checkbox"/> 36 months
Group Name _____	Date of Rehire ____/____/____		
Group Number _____	Date Transferred From Part (P/T) to Full Time (F/T) ____/____/____		
<i>*Group number should match health plan choice, if selected by employee in section below.</i>	Hours Worked Per Week ____/____/____		
<b>Choose one:</b> <input type="checkbox"/> <b>Group Health Cooperative</b> <input type="checkbox"/> <b>Group Health Options, Inc.</b>	If Retired, Date of Retirement ____/____/____		

## EMPLOYEE: COMPLETE THE FOLLOWING. PLEASE PRINT.

Employee Name \_\_\_\_\_ (Last Name) \_\_\_\_\_ (First Name) \_\_\_\_\_ (M.I.)    Marital Status:  Single     Married    Date Married \_\_\_\_/\_\_\_\_/\_\_\_\_

Mailing Address \_\_\_\_\_ Home Phone (    ) \_\_\_\_\_

Resident Address \_\_\_\_\_ (Street) \_\_\_\_\_ (City) \_\_\_\_\_ (State) \_\_\_\_\_ (Zip)    Work Phone (    ) \_\_\_\_\_

Employee Medicare Claim # \_\_\_\_\_ Former Name of Applicant or Spouse \_\_\_\_\_

**Health Plan Choice** *If more than one health plan is offered, please write in your choice, including the group number.*

\*Health Plan \_\_\_\_\_ Group Number \_\_\_\_\_

It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

FOR HEALTH PLAN INTERNAL USE ONLY	CHECK ONE		PLEASE PRINT				SOCIAL SECURITY NUMBER	MALE/FEMALE	BIRTHDATE (MM/DD/YY)	RELATIONSHIP TO EMPLOYEE
	ADD	REMOVE	LAST NAME	FIRST NAME	M.I.					
			SELF							
			DEPENDENT							
			DEPENDENT							
			DEPENDENT							
			DEPENDENT							

### DEPENDENT ELIGIBILITY INFORMATION Please list names of **married dependents**:

1. \_\_\_\_\_ (Last Name) \_\_\_\_\_ (First Name) \_\_\_\_\_ (M.I.)    2. \_\_\_\_\_ (Last Name) \_\_\_\_\_ (First Name) \_\_\_\_\_ (M.I.)

Please list names of any **dependents who are Medicare-eligible or disabled and their Medicare number**:

1. Spouse Medicare Claim # \_\_\_\_\_ 2. Dependent Name \_\_\_\_\_ 3. Medicare Claim # \_\_\_\_\_

### ADDITIONAL HEALTH BENEFITS INFORMATION

Other insurance (that is not Group Health Cooperative or Group Health Options, Inc.): \_\_\_\_\_

Who is the subscriber under this plan? \_\_\_\_\_

What is their social security or policy number with this plan? \_\_\_\_\_ Attach any certificate of creditable coverage letters to the back of this form.

**(Signature of Employee)**

**(Date Signed)**

Please retain a copy for your records