GroupHealth

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 ______________________

Group Name ______________________

Group Number ______________________

*Group number should match health plan choice, if selected by employee in section below.

Choose one: ❑ **Group Health Cooperative** ❑ **Group Health Options, Inc.**

Original Date of Hire ____/___ /____

Date of Rehire ____/___ /____

Date Transferred From Part (P/T) to Full Time (F/T) ____/___ /____

Hours Worked Per Week ____/___ /____

If Retired, Date of Retirement ____/___ /____

Choose one:

❑ Open Enrollment ❑ New Employee

❑ Address/Name Change ❑ Add Dependent(s)

❑ Remove Coverage

___ Subscriber ___ Dependent(s)

Date Processed __________ By ______________

❑ **Transfer to COBRA**

Start Date ___________

❑ 18 months

❑ 36 months

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 ______________________

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.

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

*Health Plan ______________________ Group Number ______________________

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

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

1.______________________________________ 2.______________________________________
(Last Name) (First Name) (M.I.) (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