



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				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