GroupHealth

12401 E. Marginal Way 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 _____

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

Original date of hire ____/____/____

Date of rehire ____/____/____

Date transferred from part time (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____/____/____

☐ State-registered domestic partnership

Resident address _____
(Street) (City) (State) (ZIP)

Work phone ( )_____

Mailing address (if different) _____

Home phone ( ) _____

Billing address (if different) _____

E-mail address _____
By entering your e-mail address you are agreeing to receive e-mail communications from Group Health.

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 ADD	CHECK ONE REMOVE	PLEASE PRINT LAST NAME	FIRST NAME	M.I.	SOCIAL SECURITY NUMBER	MALE/ FEMALE	BIRTHDATE (MM/DD/YY)	RELATIONSHIP TO EMPLOYEE
	☐	☐	SELF						
	☐	☐	SPOUSE/DEPENDENT						
	☐	☐	DEPENDENT						
	☐	☐	DEPENDENT						
	☐	☐	DEPENDENT						

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

Continued on other side

Employee enrollment and change form

EMPLOYEE: COMPLETE THE FOLLOWING. PLEASE PRINT.

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

NAME (FIRST AND LAST)	MEDICARE NUMBER
SPOUSE	
DEPENDENT	
DEPENDENT	

Additional health benefits information

Other coverage (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 this form.

Your contract may contain coverage exclusions for Pre-Existing Conditions (PEC). These exclusions could be fully or partially waived based on prior or current coverage. Review this section carefully and complete the information requested for both you and your dependents to assure proper processing of your claims.

NAME (FIRST AND LAST)	CURRENT OR PREVIOUS CARRIER (INCLUDE PHONE NUMBER)	COBRA	DATE COVERAGE BEGAN (MM/DD/YY)	DATE COVERAGE ENDED (MM/DD/YY)
		☐ Yes ☐ No		
		☐ Yes ☐ No		
		☐ Yes ☐ No		
		☐ Yes ☐ No		
		☐ Yes ☐ No		
		☐ Yes ☐ No		

_____

(Signature of employee) **(Date signed)**

Please retain a copy for your records.