H.I.H.I.T. Employee Enrollment and Change Form 2017

H.I.H.I.T. Hospitality Industry Health Insurance Trust

KAISER PERMANENTE® LifeMap™ Dental Health Services TRANSAMERICA Employee Benefits Ameritas fulfilling life TELADOC. COMPSYCH GuidanceResources® Worldwide

EMPLOYER: PLEASE COMPLETE THIS SECTION.

Coverage Effective Date _____/_____/_____
Group Name _____
Group Number _____
Employee Class _____
Employee Location _____

Hours Worked Per Week _____
Original Date of Hire_____/_____/_____
Date of Re-Hire _____/_____/_____
Date transferred from part time to full time
_____/_____/_____

Qualifying Event Description (choose one)
☐ Open Enrollment ☐ New Employee
☐ Add Dependent ☐ Address/name change
☐ Remove Coverage _____Subscriber _____Dependent
Date of Qualifying Event:_____/_____/_____
Prior Medical Carrier:_____
Coverage end date _____/_____/_____

☐ **Transfer to COBRA**
Start Date
____/____/____
☐ 18 Months
☐ 36 Months

EMPLOYEE: COMPLETE THE FOLLOWING. ***(PLEASE PRINT, *indicates required field)***

*Last	First	MI	*Date of Birth / /	*Gender ☐ M ☐ F	*Social Security #
*Mailing Address: City, State, Zip			*Home Phone		Work Phone
*Marital Status: ☐ Single ☐ Married Date Married: _____/_____/_____ ☐ State Registered Domestic Partnership			E-mail address*		

***Add or Remove** (circle one)	***Name of Dependent**(If dependent has different mailing address, please attach) Last First MI	***Social Security Number**	***Gender** (Circle One)	***Birth Date** (children age 26 or over requires certificate)	**Relationship to Employee**
Add/Delete	Spouse/Registered Domestic Partner		M F	/ /	
Add/Delete	Child		M F	/ /	
Add/Delete	Child		M F	/ /	
Add/Delete	Child		M F	/ /	
Add/Delete	Child		M F	/ /	

BENEFICIARY INFORMATION ***(if life benefit is offered by employer)***

Primary Beneficiary Name/Relationship:	Address:
Contingent Beneficiary Name/Relationship:	Address:

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PLAN SELECTIONS	
Medical and Prescription Drug (Rx) Plan Selection Kaiser Foundation Health Plan of Washington or Kaiser Foundation Health Plan of Washington Options, Inc	☐ **Employee only (EE)** ☐ **EE & Spouse** ☐ **EE & 1 Child** ☐ **EE & 2+ Children** ☐ **EE, Spouse & 1 Child** ☐ **EE, Spouse & 2+ Children** Please see your employer for plan details. If more than one health plan is offered, please write in your choice, including the group number below: ***Health Plan*** _____ ***Group number***_____
Dental Plan Selection LifeMap or Dental Health Services	☐ **Employee only (EE)** ☐ **EE & Spouse** ☐ **EE & Children** ☐ **EE & Family** Dental plan choice: _____
Vision Plan from Ameritas	☐ **Employee only (EE)** ☐ **EE & Spouse** ☐ **EE & Children** ☐ **EE, Spouse & Children** Vision plan choice: _____
Life Benefits from TransAmerica	☐ **20 year $25,000** ☐ **20 year $50,000** ☐ **20 year $100,000** List Beneficiary on bottom of page 1
Short Term Disability from TransAmerica	☐ **7/7 Contract** ☐ **14/14 Contract** **$**_____ **Monthly Benefit Amount** **Current Monthly Income $**_____ Monthly benefit amount must be $300 - $5,000 per month. Must not exceed 60% of monthly income.

Employee Signature: The undersigned understands that it is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purposes of defrauding the company. Penalties include imprisonment, fines and denial of 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.

Employee Signature	Date Signed

Endorsed Carrier Contact Information

Benefit Solutions, Inc : 12121 Harbour Reach Dr, Ste. 105, Mukilteo, WA 98275; Customer Service 206.456.9940
Kaiser Permanente : 320 Westlake Ave N, Ste. 100, Seattle, WA 98109; Customer Service 888.901.4636
LifeMap : 100 SW Market Street, Portland, OR 97207; Customer Service 800.794.5390
Dental Health Services : 936 N 34th St, Ste. 208, Seattle, WA 98103; Customer Service 206.633.2300
Ameritas : 5900 O Street, Lincoln, NE 68501; Customer Service 800.659.2223
Transamerica : 433 Edgewood Road NE, Cedar Rapids, IA 53499 Customer Service 800.797.2643
Teladoc : 2 Manhattanville Road, Purchase, NY 10577 Customer Service 800.835.2362
ComPsych : 455 N Cityfront Plaza Dr, Chicago, IL 60611; Customer Service 877.357.4322

For Employer Use Only

Kaiser Foundation Health Plan of Washington Options, Inc. (Access PPO): ☐ Diamond ($500 Ded.) ☐ Emerald ($1,000 Ded.) ☐ Sapphire ($1,500 Ded.) ☐ Pearl ($2,500 Ded.) ☐ Ruby ($3,000 Ded.) ☐ Ruby no Spouse ($3,000 Ded) ☐ Opal ($5,000 Ded.) ☐ Opal no Spouse ($5,000 Ded.)

Kaiser Foundation Health Plan of Washington (HMO): ☐ Jade ($1,500 Ded.) ☐ Topaz ($5,000 Ded.) ☐ Topaz no Spouse ($5,000 Ded.)

LifeMap Dental: ☐ Plan 1 ☐ Plan 2 ☐ Plan 3 **LifeMap Ortho Rider:** ☐ $1,000 ☐ $1,500 ☐ $2,000

Dental Health Services: ☐ DHSV ☐ DHS1

Ameritas Vision Plan: ☐ Plan 1 ☐ Plan 2 ☐ Plan 3 ☐ Plan 4 ☐ Plan 5 ☐ Plan 6 ☐ Plan 7 ☐ Plan 8

TransAmerica: ☐ Basic $10,000 ☐ 20 year term $25,000 ☐ 20 year term $50,000 ☐ 20 year term $100,000 ☐ Short Term Disability

Hospital Select: ☐ High - $2,500 ☐ Medium - $1,500 ☐ Low - $1,000

Teladoc: ☐ **ComPsych Employee Assistance Plan:** ☐