H.I.H.I.T. Employee Enrollment and Change Form 2020

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 Delta Dental of Washington 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: ____________________________

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

Vimly Benefit Solutions : 12121 Harbour Reach Dr, Ste. 105, Mukilteo, WA 98275; Customer Service 206.456.9940
Kaiser Permanente : 601 Union Street, Suite 3100, Seattle, WA 98101; Customer Service 888.901.4636
Delta Dental of Washington : 400 Fairview Ave N Suite 800 Seattle, WA 98109; Customer Service 800.367.4104
Dental Health Services, Limited Health Care Service Contractor : 100 West Harrison Street, Suite S-440, South Tower, Seattle, WA 98119; Customer Service 206.633.2300
Willamette Dental of Washington, Inc. 6950 NE Campus Way, Hillsboro, OR 97124 Customer Service 855.433.6825
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.) ☐ Quartz ($2,500 Ded.) ☐ Ruby ($3,000 Ded.) ☐ Ruby no Spouse ($3,000 Ded) ☐ Opal ($5,000 Ded.)

Kaiser Foundation Health Plan of Washington (HMO): ☐ Jade ($2,500 Ded.) ☐ Pearl ($2,500 Ded.) ☐ HSA ($2,500 Ded.) ☐ Onyx ($5,000 Ded.) ☐ Topaz ($5,000 Ded.)

Delta Dental of Washington: ☐ Plan 1 ☐ Plan 2 ☐ Plan 3 ☐ Plan 4 ☐ Plan 5 ☐ Plan 6 **Delta Dental of Washington Ortho Rider:** ☐ $1,000 ☐ $1,500 ☐ $2,000

Willamette Dental of Washington, Inc: ☐

Dental Health Services: ☐ DHSV ☐ DHS1

Ameritas Vision Plan: ☐ Plan 1 ☐ Plan 2 ☐ Plan 3 ☐ Plan 4 ☐ Plan 5 ☐ Plan 6 ☐ Plan 7 ☐ Plan 8 ☐ Plan 9 ☐ Plan 10

TransAmerica: ☐ Basic $10,000

Teladoc: ☐

ComPsych Employee Assistance Plan: ☐