



H.I.H.I.T. Employee Enrollment and Change Form 2021



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) <input type="checkbox"/> Open Enrollment <input type="checkbox"/> New Employee <input type="checkbox"/> Add Dependent <input type="checkbox"/> Address/name change <input type="checkbox"/> Remove Coverage Subscriber _____ Dependent _____ Date of Qualifying Event: ____/____/____ Prior Medical Carrier: _____ Coverage end date ____/____/____	<input type="checkbox"/> Transfer to COBRA Start Date ____/____/____ <input type="checkbox"/> 18 Months <input type="checkbox"/> 36 Months
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EMPLOYEE: COMPLETE THE FOLLOWING. (PLEASE PRINT, *indicates required field)

*Last	First	MI	*Date of Birth ____/____/____	*Gender <input type="checkbox"/> M <input type="checkbox"/> F	*Social Security #
*Mailing Address: City, State, Zip				*Home Phone	Work Phone
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married Date Married: ____/____/____ <input type="checkbox"/> State Registered Domestic Partnership				E-mail address	
Washington State Registered Domestic Partners are treated the same as a spouse					

*Add or Remove (circle one)	*Name of Dependent <small>(If dependent has different mailing address, please attach)</small>	*Social Security Number	*Gender (Circle One)	*Birth Date <small>(children age 26 or over requires certificate)</small>	Relationship to Employee
	Last First MI		M F	/ /	
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	<input type="checkbox"/> Employee only (EE) <input type="checkbox"/> EE & Spouse <input type="checkbox"/> EE & 1 Child <input type="checkbox"/> EE & 2+ Children <input type="checkbox"/> EE, Spouse & 1 Child <input type="checkbox"/> 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, Willamette Dental or Dental Health Services	<input type="checkbox"/> Employee only (EE) <input type="checkbox"/> EE & Spouse <input type="checkbox"/> EE & Children <input type="checkbox"/> EE & Family Dental plan choice: _____
Vision Plan from Ameritas	<input type="checkbox"/> Employee only (EE) <input type="checkbox"/> EE & Spouse <input type="checkbox"/> EE & Children <input type="checkbox"/> 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): <input type="checkbox"/> Diamond (\$500 Ded.) <input type="checkbox"/> Emerald (\$1,000 Ded.) <input type="checkbox"/> Sapphire (\$1,500 Ded.) <input type="checkbox"/> Quartz (\$2,500 Ded.) <input type="checkbox"/> Ruby (\$3,000 Ded.) <input type="checkbox"/> Ruby no Spouse (\$3,000 Ded) <input type="checkbox"/> Opal (\$5,000 Ded.)	
Kaiser Foundation Health Plan of Washington (HMO): <input type="checkbox"/> Jade (\$2,500 Ded.) <input type="checkbox"/> Pearl (\$2,500 Ded.) <input type="checkbox"/> HSA (\$2,500 Ded.) <input type="checkbox"/> Onyx (\$5,000 Ded.) <input type="checkbox"/> Topaz (\$5,000 Ded.) <input type="checkbox"/> Zircon (\$5,000 Ded.) <input type="checkbox"/> Virtual Plus 1000 <input type="checkbox"/> Virtual Plus 2000 <input type="checkbox"/> Virtual Plus 3000 <input type="checkbox"/> Virtual Plus 5000	
Delta Dental of Washington: <input type="checkbox"/> Plan 1 <input type="checkbox"/> Plan 2 <input type="checkbox"/> Plan 3 <input type="checkbox"/> Plan 4 <input type="checkbox"/> Plan 5 <input type="checkbox"/> Plan 6 Delta Dental of Washington Ortho Rider: <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$1,500 <input type="checkbox"/> \$2,000	
Willamette Dental of Washington, Inc: <input type="checkbox"/>	
Dental Health Services: <input type="checkbox"/> DHSV <input type="checkbox"/> DHS1	
Ameritas Vision Plan: <input type="checkbox"/> Plan 1 <input type="checkbox"/> Plan 2 <input type="checkbox"/> Plan 3 <input type="checkbox"/> Plan 4 <input type="checkbox"/> Plan 5 <input type="checkbox"/> Plan 6 <input type="checkbox"/> Plan 7 <input type="checkbox"/> Plan 8 <input type="checkbox"/> Plan 9 <input type="checkbox"/> Plan 10	
TransAmerica: <input type="checkbox"/> Basic \$10,000	
Teladoc: <input type="checkbox"/> ComPsych Employee Assistance Plan: <input type="checkbox"/>	