



WBBA
January 2010 - December 2010
Enrollment & Change Form

Program Management Provided By
Wells Fargo Insurance Services

1. Group Information (to be completed by the group)

Group Name:	<input type="checkbox"/> New	Effective Date: _____
Group ID # (tbd for new groups):	<input type="checkbox"/> Change	Date of Hire: _____
Reason:	<input type="checkbox"/> Hire/Rehire <input type="checkbox"/> Open Enrollment <input type="checkbox"/> Loss of Coverage <input type="checkbox"/> Birth/Adoption <input type="checkbox"/> Address/Name Change <input type="checkbox"/> Add Dependand(s) Date: _____ <input type="checkbox"/> Remove Dependand(s) Date: _____ Reason _____ <input type="checkbox"/> Date of Termination _____ Reason _____	

2. Employee Information (employee to complete sections 2 through 6)

Employee Name: (last, first, middle initial)	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Married <input type="checkbox"/> Unmarried	Date of Birth	Home Phone: () -	Social Security No. - -
Street Address: City State Zip	Mailing Address (if different): City State Zip				

3. Enrollment Information

Medical Plan Enrollment (Underwritten by Premera Blue Cross for plans A-I and HSA \$1,700 and \$2,500; Group Health Options, Inc. for Plans 5 & 10):

<input type="checkbox"/> Plan A \$0 Ded. 0/50% \$20 Copay	<input type="checkbox"/> Plan D \$300 Ded, 20/50% \$20 Copay	<input type="checkbox"/> Plan G \$1,000 Ded 20/50%	<input type="checkbox"/> Plan HSA \$2,500 Ded. 20/50%
<input type="checkbox"/> Plan B \$200 Ded. 0/50% \$15 Copay	<input type="checkbox"/> Plan E \$500 Ded. 20/50% \$25 Copay	<input type="checkbox"/> Plan HSA \$1,700 Ded. 20/50%	<input type="checkbox"/> Alliant Select Health Plan 5
<input type="checkbox"/> Plan C \$250 Ded, 10/50% \$20 Copay	<input type="checkbox"/> Plan F \$750 Ded. 20/50% \$25 Copay	<input type="checkbox"/> Plan I \$2,000 Ded 20/50%	<input type="checkbox"/> Alliant Plus Health Plan 10

Dental Plan Enrollment (Underwritten by Washington Dental Service): Only available if chosen by your employer. Dental enrollment must match other lines of coverage.

Vision Plan Enrollment (Underwritten by Vision Service Plan): Only available if chosen by your employer. Vision enrollment must match other lines of coverage.

Life & AD&D (Underwritten by Unum Life Insurance Co. of America): Basic Life/AD&D is only available if chosen by your employer and enrollment is automatic. Supplemental coverage requires a separate application. Amounts over the Guaranteed Issue will be subject to health underwriting. Employee Salary (for Plans 3 & 4): _____

Employee Assistance Program (EAP) (Offered by Wellspring Family Services): Only available if chosen by your employer and enrollment is automatic.

NOTE: In order for dependents to qualify for coverage, the employee must select the same benefit. Indicate each member's name as you would like it to appear on the ID Card.

Add	Drop	Relationship	Last Name	First Name	MI	Social Security No.	Date of Birth	Gender		Benefit Selection		
								M	F	MED	DENT	VIS
<input type="checkbox"/>	<input type="checkbox"/>	Spouse				- -		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>					- -		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>					- -		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>					- -		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>					- -		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or employer group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if, in the case of employer group health plan coverage, the employer stops contributing toward you or your dependents' other coverage.) However, you must request enrollment within 60 Days after you or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). In addition, if you gain a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 60 days after the marriage, birth, adoption, or placement for adoption.

4. Prior Medical Coverage (Preexisting condition waiting period is 3 months. Period may be credited with prior, continuous coverage). Complete only if other group coverage continues in force

Prior Coverage?

Yes No (if 'Yes' indicate Prior Coverage on below)

Prior Medical Carrier and Policy #:

List all participants enrolled in prior medical plan:

Duration of coverage:

Eff. Date: _____ Term. Date: _____

5. Coordination of Benefits

Other Insurance Carrier:

Policy ID #:

Effective Date:

Policy Holder's Name:

Phone #:

Date of Birth:

Social Security #:
- -

If you have Medicare What is the Begin date for:

Part A:

Part B:

Medicare HIC # with Alpha Suffix:

6. Designation of Beneficiary

EMPLOYEE BENEFICIARY:	Primary Beneficiary Name and Relationship* for Basic life/AD&D & Supplemental Life/AD&D	Primary Beneficiary Address	City	State	Zip
EMPLOYEE BENEFICIARY:	Contingent Beneficiary Name and Relationship** for Basic life/AD&D & Supplemental Life/AD&D	Contingent Beneficiary Address	City	State	Zip

* If more than one primary beneficiary is named, the primary beneficiaries shall share equally unless otherwise indicated. ** Contingent Beneficiary(ies) will only receive proceeds if all Primary Beneficiaries have predeceased the Insured. If you are naming more than one Contingent Beneficiary at 100% each, please indicate them in order of precedence.

7. Signature

I hereby apply for enrollment or change of enrollment as indicated on this application. I understand that the WBBA and the Insurers may collect, use and disclose protected health information about each individual enrolled under this application in order to carry out their routine business functions, including but not limited to, determining eligibility for benefits, paying claims, coordinating benefits with other insurance carriers or payer, underwriting and conducting case management care management and quality reviews. The WBBA and the Insurers may also disclose protected health information to state and federal agencies, or other third parties, as required by law. I understand that information collected in connection with administration of the benefit plan may be used to bring to my attention health products or services that might be valuable to me and otherwise as permitted by law.

I understand that the health benefit plan that I have selected provides reimbursement for certain medical costs, which are more fully described in the current Certificate of Coverage. I understand there may be instances where treatment decisions made by my physician or me or medical expenses which I have incurred may not be covered by my health benefit plan. 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:

Employer Signature

Date:

8. Endorsed Carrier Contact Information

Premera Blue Cross: 7001 220th Street S.W., Mountlake Terrace, WA 98043; Customer Service - 800.722.1471
Group Health Options, Inc.: 320 Westlake Ave. N., Suite 100, Seattle, WA 98109; Customer Service - 888.901.4636
Washington Dental Service: 9706 Fourth Ave. N.E., Seattle, WA 98115; Customer Service - 800.554.1907
Vision Service Plan: 3333 Quality Drive, Rancho Cordova, CA 95670; Customer Service - 800.877.7195
Unum Life Insurance Company of America: 2211 Congress Street, Portland, ME 04122; Customer Service – 800.421.0344
Wellspring Family Services: 1900 Rainier Avenue South; Seattle, WA 98144; Customer Service – 800.553.7798

Please return form to Benefit Solutions, Inc.
12121 Harbour Reach Drive, Suite 105
Mukilteo, WA 98275-0006
Fax – 425.771.1226