Washington Cascade Employer Health Insurance Trust
Employee Enrollment/Change Form

TO COMPLY WITH WASHINGTON LAW, WHEREVER THE TERM "SPOUSE" APPEARS IT WILL BE CONSTRUED TO INCLUDE DOMESTIC PARTNER.

Life, Accidental Death & Dismemberment, and Aetna PPO and Traditional plans are underwritten by Aetna Life Insurance Company. Dental Plans are provided by Aetna Life Insurance Company.

Member Aetna ID Number (if available)

Employer Name

INSTRUCTIONS: You, the employee, must complete this enrollment form in full or it will be returned to you resulting in a delay in processing. You are solely responsible for its accuracy and completeness. If waiving coverage, please complete Sections B and F.

Effective Date

Date of Hire

☐ New Hire
☐ Rehire/Reinstatement
☐ New Group Enrollment
☐ Late Enrollment
☐ Other

☐ Change of Coverage
☐ Add Spouse/Dependent Child
☐ Name Change
☐ Other

☐ Employee Termination
☐ Remove Spouse/Dependent Child
☐ Cancel Coverage

COBRA/State Continuation for:
☐ Employee ☐ Dependent
Length of Continuation:
☐ 18 ☐ 36 ☐ Other
Original Qualifying Event Date
Reason

A. Coverage Selection – *Please print clearly, using black ink. (Shaded sections for Employer/Aetna Use Only)*

Control/Group No.	Suffix	Account	Plan No.	Class Code

Control/Group No.	Suffix	Account	Plan No.

Control/Group No.	Suffix	Account	Plan No.

1. Medical - Check one.
- ☐ PPO 250 90/60
- ☐ PPO 250 80/60
- ☐ PPO 500 80/50
- ☐ PPO 750 80/50
- ☐ PPO 1000 80/50
- ☐ PPO 1500 80/50
- ☐ PPO Value 750 80/50
- ☐ PPO Value 1000 80/50
- ☐ PPO Value 1500 80/50
- ☐ PPO Saver 2500 70/50
- ☐ PPO Saver 5000 80/50
- ☐ PPO HSA HDHP 1500 80/50
- ☐ PPO HSA HDHP 2500 80/50
- ☐ Indemnity

2. Dental - Check one.

Standard Plans
- ☐ Option 1: Scheduled Plan
- ☐ Option 2: Freedom-of-Choice ☐ DMO® or ☐ PPO
- ☐ Option 3-09: PPO 1000, 90th
- ☐ Option 4-09: PPO 1000, 90th w/ Ortho
- ☐ Option 5: PPO Max
- ☐ Option 6-09: PPO 1500, 90th
- ☐ Option 7-09: PPO 1500, 90th w/ Ortho
- ☐ Option 8-09: PPO 2000, 90th
- ☐ Option 9-09: PPO 2000, 90th w/ Ortho
- ☐ Option 10-09: Indemnity U&C
- ☐ Option 11-09: DMO® Access
- ☐ Out-of-State Indemnity U&C

Voluntary Plans
- ☐ Option 1-09: PPO 1000
- ☐ Option 2-09: PPO 1000, 90th
- ☐ Out-of-State Indemnity U&C

Before today, were you covered under this employer's dental plan? ☐ Yes ☐ No

3. Life
- ☐ Basic Life/AD&D Ultra®
- ☐ Optional Dependent Life

Beneficiary Designation - **Full Name** (First, Middle, Last)

Beneficiary Social Security Number

Relationship to Employee

B. Employee Information - *Must be completed by the employee.*

Social Security Number	Last Name, First Name, M.I.	Job Title	Home Telephone	Primary Language Spoken (Optional)

Home Address	Apt. No.	City, State	ZIP Code

Work Address	City, State	ZIP Code	Work Telephone

Salary	No. of Hours Worked Per Week	Check One	No. of Dependents Including Spouse
$ ☐ Hourly ☐ Weekly ☐ Monthly		☐ Full-Time ☐ Part-Time	

C. Individuals Covered - *List individuals for whom you are enrolling or adding/changing/removing coverage. Insert additional sheets if necessary.*

NOTE FOR MEDICAL AND DENTAL COVERAGE: While the Federal Patient Protection and Affordable Care Act mandates coverage of dependent children up to age 26, your plan may allow coverage beyond age 26. Some exceptions apply. Please refer to your plan documents or contact your benefits administrator.

(A)dd (C)hange (R)emove	Name (Last, First, M.I.)	Sex M/F	Social Security Number	Birthdate (MM/DD/YYYY)	Height (ft, in)	Weight (lbs)	Status	Coverage Election	Primary Office ID Number (if applicable)	Current Patient
	Employee 1.			/ /			☐ Single ☐ Divorced ☐ Married ☐ Widowed ☐ Legally Separated	☐ Medical ☐ Dental ☐ Life		Yes ☐
	Spouse/Domestic Partner 2.			/ /			☐ Different Last Name	☐ Medical ☐ Dental ☐ Life		☐
	Child 3.			/ /			☐ Different Last Name ☐ Lives at another address ☐ Disabled	☐ Medical ☐ Dental ☐ Life		☐
	Child 4.			/ /			☐ Different Last Name ☐ Lives at another address ☐ Disabled	☐ Medical ☐ Dental ☐ Life		☐

D. Dependent Information

List any dependent in Section C living at another address.	Name:	Reason:	Address:
If any dependent's last name differs from yours, explain.	Name:	Reason:	

E. Race/Ethnicity – Optional (This information is designed for the purpose of data collection and will not be used for determining eligibility, rating or claim payment.)

Employee 1.	☐ White – 01 ☐ African American or Black – 02 ☐ Hispanic or Latino – 03 ☐ Asian – 04 ☐ Other – 05 _____	Child 3.	☐ White – 01 ☐ African American or Black – 02 ☐ Hispanic or Latino – 03 ☐ Asian – 04 ☐ Other – 05 _____
Spouse 2.	☐ White – 01 ☐ African American or Black – 02 ☐ Hispanic or Latino – 03 ☐ Asian – 04 ☐ Other – 05 _____	Child 4.	☐ White – 01 ☐ African American or Black – 02 ☐ Hispanic or Latino – 03 ☐ Asian – 04 ☐ Other – 05 _____

F. Declination/Waiver of Coverage - *To be completed ONLY if medical and/or dental coverage is declined or refused by an eligible employee and/or their eligible family members.*

1. Medical Coverage Declined for:
   ☐ Myself ☐ Spouse ☐ Dependents
2. Dental Coverage Declined for:
   ☐ Myself ☐ Spouse ☐ Dependents

Reason for Declining Coverage *(If applicable, please attach front/back of your health coverage ID card.)*:
☐ Covered by spouse's group coverage - Carrier Name and ID _____
☐ Enrolled in other Insurance Carrier Plans - Carrier Name and ID _____
☐ Spouse covered by medical coverage ☐ Spouse covered by employer's group dental coverage
☐ Spouse covered by employer's group coverage
☐ Medicare ☐ Covered by TRICARE or CHAMPVA ☐ Medicaid ☐ Indian Health Services ☐ Other _____

I acknowledge I have been given the right to apply for this coverage, however, I am electing not to enroll for the reason checked above. By declining this group coverage I acknowledge that myself and/or my dependents may have to wait until the plan's next anniversary date to be enrolled for group coverage. Pre-existing conditions may not be covered for three (3) months. NOTE: If your Plan contains a pre-existing conditions provision, the pre-existing conditions exclusion and limitation will not apply to a person under 19 years of age.

Please sign here ONLY if you are declining coverage for yourself and/or dependent(s).	***Date (Month/Day/Year)***
X Employee Signature	

G. Other Insurance

Does anyone age 19 and over enrolling on this enrollment form have current or prior medical and/or dental coverage? ☐ Yes ☐ No

Proof of coverage should accompany this enrollment form for pre-existing condition credit and if an employee is waiving coverage. Acceptable forms of proof are:
1. Certificate of Creditable Coverage from prior carrier, or
2. Copy of ID card or most recent payroll stub showing medical coverage deduction, or
3. Copy of most recent medical premium bill from prior carrier.

Failure to provide Proof of Prior Coverage may subject you or a family member (age 19 and over) to the full pre-existing conditions limitation with no credit for prior coverage. You may request a Certificate of Creditable Coverage from your prior carrier. NOTE: If your Plan contains a pre-existing conditions provision, the pre-existing conditions exclusion and limitation will not apply to a person under 19 years of age.

Name of Covered Individual	Carrier Name	Group Number	Start Date	Termination Date	Health	Dental
					☐ Yes ☐ No	☐ Yes ☐ No
					☐ Yes ☐ No	☐ Yes ☐ No

H. Medicare Information

Name of Person	Medicare Part A	Medicare Part B	Medicare Part D	Over Age 65	Disability	End-Stage Renal Disease Eff Date
	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	

Conditions of Enrollment

On behalf of myself and the dependents listed on the reverse side, I agree to or with the following:

1. I acknowledge that by enrolling in the following plans, coverage is provided by Aetna Life Insurance Company (referred to as "Aetna"): Aetna PPO plans, Life, Accidental Death & Dismemberment, dental and all other coverages.
2. I understand and agree that my employer's enrollment form will determine coverage and that there is no coverage unless and until both the eligible employee enrollment form and employer applications have been accepted and approved by Aetna. Even if this enrollment form is approved, any misstatements or omissions may result in future claims being denied and the policy or my coverage under the policy being rescinded or reevaluated, as of the effective date, for eligibility and rating purposes. *For life coverages:* I understand that the effective date of insurance for myself or for any of my dependents is subject to my being actively at work on that date and that the effective date of insurance for any of my dependents is also subject to the dependent health condition requirements of the benefit plan. Further, I understand that any insurance subject to evidence of good health or medical information will not become effective until Aetna gives its written consent. For Dependent Life, dependents are eligible from 14 days of age up to their 19th birthday or up to their 23rd birthday, if a full-time student.
3. Authorizations signed for the purpose of collecting information in connection with this enrollment form for an insurance policy, a policy reinstatement or a request for a change in policy benefits shall remain valid for thirty (30) months from the date signed. Authorizations signed for the purpose of collecting information in connection with a claim for benefits shall remain valid for the term of this coverage or for so long as allowed by law. The information, as well as other personal or privileged information, subsequently collected by the insurance institution or insurance producer may, in certain circumstances, be disclosed to third parties without authorization. A right of access and correction exists with respect to all personal information collected. Further disclosures required by Washington law will be furnished to the policyholder upon request. Personal information may be collected from persons other than the individual or individuals proposed for coverage.
4. The plan documents will determine the rights and responsibilities of member(s) and will govern in the event they conflict with any benefits comparison, summary or other description of the plan.
5. I understand and agree that providers and vendors are independent contractors in private practice and are neither employees nor agents of Aetna or its affiliates. The availability of any particular provider cannot be guaranteed, and provider network composition is subject to change.
6. I understand and agree that, with certain exceptions described in the plan documents, DMO plans only provide coverage for referred benefits, and that, in order to be covered, services must be performed either by a participating primary care physician, primary care dentist, or by the participating specialist, hospital, pharmacy, dentist, or other provider as authorized by a referral from a participating primary care physician.
7. I understand and agree that, as described in the plan documents, any pre-existing conditions for my spouse, dependents or myself may not be covered for 3 months. NOTE: If your Plan contains a pre-existing conditions provision, the pre-existing conditions exclusion and limitation will not apply to a person under 19 years of age.

I represent that all information supplied in this form is true and complete. I have read and agree to the Conditions of Enrollment on this Cascade Employer Health Insurance Trust Employee Enrollment/Change Form. I understand that, in the event I fail to sign this form within 31 days after the above transaction request or for any reason Aetna does not receive notice of the above transaction request within a reasonable time following the event, my and my dependents' eligibility may be affected. I am employed by the employer shown on Page 1 at the regular place of business.

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.

Employee Signature	***Employee E-mail Address (optional)***	***Date (Month/Day/Year)***
X		