NORTHWEST EMPLOYERS MARKETPLACE

Offered through Evergreen Security Trust

Employee Enrollment Application and Change Form for medical, dental, vision, and life coverage.

Enrollment must be the same across all lines of coverage for employees. Uncommon enrollment for dental is allowed for dependents only.

Effective Date of Enrollment, Termination or Change:		**Employer Name:**		**Employee Class:**	
Check One: ☐ **New Enrollee** ☐ **Open Enrollment** ☐ **Waiving** ☐ **Add/Delete Dependents** ☐ **Cancellation** ☐ **COBRA/COC** ☐ **Name Change** ☐ **Address Change** ☐ **Voluntary Dental only**				**Group Number:**	

Employee Personal Information (Please Print Clearly)

First Name:	**MI:**	**Last Name:**	**Gender:**
Date of Birth:		**Marital Status:**	**Date of Marriage or Domestic Partnership:**
SSN:	**Date of Hire:**	**Hours per week:**	**Phone:**
Address:			**Medical Plan Choice** (if multiple plans are offered)**:**
Qualifying Event and date:			
Prior medical coverage info:	**Carrier:**	**Start date:**	**End date:**

Name of Enrolling Dependent(s):	**Date of Birth:**	**Relationship:**	**Gender:**	**SSN:**	**Add**	**Delete**	**Dental**
1)		☐ Spouse ☐ DP			☐	☐	☐
2)		Child			☐	☐	☐
3)		Child			☐	☐	☐
4)		Child			☐	☐	☐
Beneficiary for Basic Life / AD&D Insurance Benefit					☐	☐	☐

Name:	**Relationship:**	**Address:**

Dental Coverage Underwritten by:	**Delta Dental Of Washington;** 400 Fairview Avenue North, Suite 800, Seattle, WA 98109-5371
Vision Coverage Underwritten by:	**Vision Service Plan;** 600 University Street, Suite 2004, Seattle, WA 98101
Life/AD&D Coverage Underwritten by:	**LifeMap Assurance Company;** PO Box 1271, MS E3A, Portland, OR 97297-1271
Administered by:	**Vimly Benefit Solutions, Inc.;** 12121 Harbour Reach Drive, Suite 105, Mukilteo, WA 98275

Mailing Address: PO Box 6, Mukilteo, WA 98275 Phone: (425) 771-7359 Fax: (425) 771-1226 Email: nwem@vimly.com

Terms & Conditions

Application Agreement: I hereby apply for coverage under the contract between the issuer and my employer or group, and I agree with the terms of the contract. I also apply for the same coverage for my spouse and domestic partner and/or my children listed on this application. I certify that my listed dependents and I meet all the eligibility criteria set forth in the outline of benefits and/or the contract. I agree to pay in advance the appropriate rates for myself and listed dependents and authorize rate increases as the company deems necessary.

Anti-Fraud Statement: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. I have provided these answers as part of the application procedure required by the issuer to enroll in coverage and I certify that all information completed on this form is true, correct, and complete. I understand that the issuer will rely on each answer in making coverage and rating determinations. Penalties include imprisonment, fines, and denial of insurance benefits.

Release of Information: I acknowledge and understand my health plan may request or disclose health information about me or my dependents (persons who are eligible for benefits coverage and are listed on the enrollment form) for the purpose of facilitating health care treatment, payment or for the purpose of business operations necessary to administer health care benefits; or as required by law. Health information requested or disclosed may be related to treatment or services performed by: a physician, dentist, pharmacist or other physical or behavioral health care practitioner; a clinic, hospital, long term care or other medical facility; any other institution providing care treatment, consultation, pharmaceuticals or supplies; or an insurance carrier or group health plan. Health information requested or disclosed may include, but is not limited to: claims records, correspondence, medical records, billing statements, diagnostic imaging reports, laboratory reports, dental records, or hospital records (including nursing records and progress notes). This acknowledgement does not apply to obtaining information regarding psychotherapy notes. A separate authorization will be used for psychotherapy notes.

By signing below, I acknowledge that I have read, understand and agree to the Terms & Conditions on this form.

Signature:	**Date:**