

## Northwest Employers Marketplace Employee Enrollment Application, Cancellation, and Waiver

<b>Effective Date of Enrollment, Termination or Change:</b>	/01/	<b>Employer Name:</b>		<b>Employee Class</b>		
<b>Check One</b>	<input type="checkbox"/> New Enrollee	<input type="checkbox"/> Cancellation	<input type="checkbox"/> Name Change	<input type="checkbox"/> Add Dependents	<input type="checkbox"/> Delete Dependents	<input type="checkbox"/> Address Change
	<input type="checkbox"/> Waiving	<input type="checkbox"/> COBRA	<input type="checkbox"/> Voluntary Dental			
<b>Personal Information:</b> (Please Print Clearly)						
<b>Employee Name:</b>	Last: _____			<b>SSN:</b> _____		
	First: _____ M.I: _____			<b>Date of Birth:</b> ____ / ____ / ____		
<b>Address:</b>	_____			<b>Hire Date:</b> ____ / ____ / ____		
<b>City:</b>	_____	<b>State:</b>	_____	<b>Zip Code:</b>	_____	<b>Hours per week:</b> _____
<b>Phone:</b> ( ) _____	<b>Marital Status:</b>	_____	<b>Date of Marriage:</b>	_____	<b>Gender:</b>	<input type="checkbox"/> Male <input type="checkbox"/> Female
<b>Name of Enrolling Dependent(s)</b>	<b>Birth Date</b>	<b>Relationship to Employee</b>	<b>Sex</b>	<b>SSN</b>		
1)		<input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Child	<input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> Add <input type="checkbox"/> Delete	
2)		<input type="checkbox"/> Child	<input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> Add <input type="checkbox"/> Delete	
3)		<input type="checkbox"/> Child	<input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> Add <input type="checkbox"/> Delete	
4)		<input type="checkbox"/> Child	<input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> Add <input type="checkbox"/> Delete	
5)		<input type="checkbox"/> Child	<input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> Add <input type="checkbox"/> Delete	
6)		<input type="checkbox"/> Child	<input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> Add <input type="checkbox"/> Delete	
<b>Beneficiary for Basic Life / AD&amp;D Insurance Benefit</b>						
<b>Name:</b>	_____			<b>Relationship:</b>	_____	
<b>Address:</b>	_____					
<b>By signing below, I acknowledge that I have read, understand and agree to the Terms &amp; Conditions on all pages of this form.</b>						
<b>Employee Signature</b>					<b>Date</b>	
_____					_____	

<b>Dental Coverage Underwritten by</b> Delta Dental Of Washington; 9706 Fourth Avenue NE – Seattle, WA 98115-2157
<b>Vision Coverage Underwritten by</b> Vision Service Plan; 600 University Street, Suite 2004; Seattle, WA 98101
<b>Life/AD&amp;D Coverage Underwritten by</b> LifeMap Assurance Company; PO Box 1271, MS E3A – Portland, OR 97297-1271

Administered by Benefit Solutions, Inc.

Physical address:

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

E-mail:

nwem@bsitpa.com

# **Northwest Employers Marketplace Employee Enrollment Application, Cancellation, and Waiver**

## **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/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.