PREMERA HMO

PO Box 3048, MS 737
Spokane, WA 99220-3048

Member enrollment and change application

Use the Member Enrollment and Change Application form to apply for enrollment or drop dependents from your plan. Please print as clearly as possible to avoid delays in processing your application.

Please keep in mind

- If any dependent has a different mailing address, please attach that information.
- If any child over the dependent age limit is applying for coverage due to disability, please complete and attach the Request for Certification of Disabled Dependent form.
- If any applicant has other coverage through another plan, including Medicare or Premera Blue Cross HMO that will remain in effect when your coverage begins, complete and attach the Other Coverage Questionnaire form. If the form is not included, then it is assumed that no other coverage is in effect.

To find the Request for Certification of Disabled Dependent form and the Other Coverage Questionnaire, go to:

- premera.com, scroll to the bottom of the page and click on forms.
- They will be under the Enrollment and changes section.

Next steps

To help process your form, please make sure it's fully completed, signed, and returned with all required information and documents (as applicable).

Submit your application one of two ways

Mail to:
Premera Blue Cross HMO
PO Box 3048, MS 737
Spokane, WA 99220-3048

Email to:
premeramembership@premera.com

Questions?

Call:
844-722-HMO1(4661) (TTY: 711)
Monday through Friday
5 a.m. to 8 p.m. Pacific Time

PREMERA HMO

Mail to:
PO Box 3048, MS 737
Spokane, WA 99220-3048
premera.com

Small Group Member Enrollment and Change Application

General information (group complete) **All fields are required**			
Group ID	Group name	Employee class/subgroup (as applicable)	Employee hire date / /
Enrollment reason	Enrollment reason date ☐ Same as hire date ☐ Other date / /	If COBRA, indicate number of months: ☐ 18 months ☐ 29 months ☐ 36 months	Plan start date / /

Employee information (employee complete) **All fields are required** | Please indicate names as you would like them to appear on the ID card. (Limit 26 characters including spaces)					
Employee name (Last)	(First)	Phone number ( )	Email address		
Mailing address		City	State	ZIP	

Enrollment information (employee complete) **All fields are required**
Medical plan choice

Relationship to employee	Last name	First name	Social Security number	Date of birth	Gender	Add	Drop	Benefit selection
Self				/ /		☐	☐	☐ **Medical**

SSN is required for any member over the age of 44.

Primary language	**Ethnicity – check all that apply** (optional)		
☐ English ☐ Spanish ☐ Other _____	☐ American Indian/Alaskan Native ☐ Asian ☐ Black African American	☐ Native Hawaiian/Pacific Islander ☐ Hispanic/Latino	☐ Not Hispanic or Latino ☐ White

Relationship to employee	Last name	First name	Social Security number	Date of birth	Gender	Add	Drop	Benefit selection
				/ /		☐	☐	☐ **Medical**

Primary language	**Ethnicity – check all that apply** (optional)		
☐ English ☐ Spanish ☐ Other ____________	☐ American Indian/Alaskan Native ☐ Asian ☐ Black African American	☐ Native Hawaiian/Pacific Islander ☐ Hispanic/Latino	☐ Not Hispanic or Latino ☐ White

Relationship to employee	Last name	First name	Social Security number	Date of birth	Gender	Add	Drop	Benefit selection
				/ /		☐	☐	☐ **Medical**

SSN is required for any member over the age of 44.

Primary language	**Ethnicity – check all that apply** (optional)		
☐ English ☐ Spanish ☐ Other ____________	☐ American Indian/Alaskan Native ☐ Asian ☐ Black African American	☐ Native Hawaiian/Pacific Islander ☐ Hispanic/Latino	☐ Not Hispanic or Latino ☐ White

Relationship to employee	Last name	First name	Social Security number	Date of birth	Gender	Add	Drop	Benefit selection
				/ /		☐	☐	☐ **Medical**

SSN is required for any member over the age of 44.

Primary language	**Ethnicity – check all that apply** (optional)		
☐ English ☐ Spanish ☐ Other ____________	☐ American Indian/Alaskan Native ☐ Asian ☐ Black African American	☐ Native Hawaiian/Pacific Islander ☐ Hispanic/Latino	☐ Not Hispanic or Latino ☐ White

Relationship to employee	Last name	First name	Social Security number	Date of birth	Gender	Add	Drop	Benefit selection
				/ /		☐	☐	☐ **Medical**

SSN is required for any member over the age of 44.

Primary language	**Ethnicity – check all that apply** (optional)		
☐ English ☐ Spanish ☐ Other ____________	☐ American Indian/Alaskan Native ☐ Asian ☐ Black African American	☐ Native Hawaiian/Pacific Islander ☐ Hispanic/Latino	☐ Not Hispanic or Latino ☐ White

Relationship to employee	Last name	First name	Social Security number	Date of birth	Gender	Add	Drop	Benefit selection
				/ /		☐	☐	☐ **Medical**

SSN is required for any member over the age of 44.

Primary language	**Ethnicity – check all that apply** (optional)		
☐ English ☐ Spanish ☐ Other ____________	☐ American Indian/Alaskan Native ☐ Asian ☐ Black African American	☐ Native Hawaiian/Pacific Islander ☐ Hispanic/Latino	☐ Not Hispanic or Latino ☐ White

Employee signature

In applying for enrollment as indicated on this application, I declare that all of the information on this form is true and complete to the best of my knowledge. I also declare that each person I am requesting enrollment for is eligible for coverage. I have also read and understand the provisions as stated in the Notices section of this document. The changes on this form supersede all previous forms submitted.

Employee signature_____ Date signed _____/_____ /_____

Please note: *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.*

Notices

Premera privacy policy

We may collect, use, or disclose personal information about you, including health information, your address, telephone number or Social Security number. We may receive this information from, or release it to, healthcare providers, insurance companies, or other sources to conduct our routine business operations such as: underwriting and determining your eligibility for benefits and paying claims; coordinating benefits with other healthcare plans; or conducting care management, case management, or quality reviews. This information may also be collected, used, or released as required or permitted by law.

To safeguard your privacy and ensure your information remains confidential, we train all employees on our written confidentiality policy and procedures. If a disclosure of your personal information is not related to a routine business function, we will remove anything that could be used to easily identify you, unless we have your prior authorization to release such information.

You have the right to request inspection and/or amendment of your records retained by us.

To view or print copies of our detailed Privacy Notice and other forms, please visit our website at premera.com. To have forms mailed to you, please call the number below.

Special enrollment rights

If you are declining enrollment for yourself or dependents because of other healthcare coverage, in the future you may enroll yourself or your dependents in this plan prior to the next open enrollment period. To do this, you must have involuntarily lost your other coverage and we must receive your enrollment application within 60 days after your other coverage ended. Additionally, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and dependents, provided we receive your completed enrollment application within 60 days after the event, unless a different time limit has been specified in your benefit booklet.

Late enrollees and state continuation of coverage

A late enrollee is an individual or family dependent who did not enroll when first eligible for coverage under this plan. A late enrollee doesn't qualify as a special enrollee. If you or your dependents are late enrollees, you may enroll during the next annual group enrollment period.

If you are enrolling under state continuation of coverage (COC), the eligible period of coverage cannot exceed 3 months

Required Social Security number and contact email address

Under the Affordable Care Act (ACA), all health plans must provide an IRS Form 1095-B to fully insured members starting in 2016. You'll need Form 1095-B to help you file your taxes, much like your W-2.

If you have any questions about the information included in this notice, please call us at 844-722-HMO1(4661).

PREMERA HMO

Discrimination is Against the Law

Premera Blue Cross HMO (Premera HMO) complies with applicable Federal and Washington state civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, gender identity, or sexual orientation. Premera HMO does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, gender identity, or sexual orientation. Premera HMO provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats). Premera HMO provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages. If you need these services, contact the Civil Rights Coordinator. If you believe that Premera HMO has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, gender identity, or sexual orientation, you can file a grievance with: Civil Rights Coordinator ─ Complaints and Appeals, PO Box 91102, Seattle, WA 98111, Toll free: 855-332-4535, Fax: 425-918-5592, TTY: 711, Email AppealsDepartmentInquiries@Premera.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Ave SW, Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html. You can also file a civil rights complaint with the Washington State Office of the Insurance Commissioner, electronically through the Office of the Insurance Commissioner Complaint Portal available at https://www.insurance.wa.gov/file-complaint-or-check-your-complaint-status, or by phone at 800-562-6900, 360-586-0241 (TDD). Complaint forms are available at https://fortress.wa.gov/oic/onlineservices/cc/pub/complaintinformation.aspx.

Language Assistance

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 844-722-4661 (TTY: 711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 844-722-4661（TTY：711）。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 844-722-4661 (TTY: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 844-722-4661 (TTY: 711) 번으로 전화해 주십시오.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 844-722-4661 (телетайп: 711).

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 844-722-4661 (TTY: 711).

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 844-722-4661 (телетайп: 711).

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 844-722-4661 (TTY: 711)។

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。844-722-4661（TTY:711）まで、お電話にてご連絡ください。

ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 844-722-4661 (መስማት ለተሳናቸው: 711).

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 844-722-4661 (TTY: 711).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 844-722-4661 (رقم هاتف الصم والبكم: 711).

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 844-722-4661 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ।

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 844-722-4661 (TTY: 711).

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 844-722-4661 (TTY: 711).

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 844-722-4661 (TTY: 711).

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 844-722-4661 (ATS : 711).

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 844-722-4661 (TTY: 711).

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 844-722-4661 (TTY: 711).

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 844-722-4661 (TTY: 711).

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 844-722-4661 (TTY: 711) تماس بگیرید.