PREMERA | BLUE CROSS

Member Enrollment and Change Application

Employer completes this section

General Information
All fields are required

Group ID	Group name	Employee class/subgroup (as applicable)	Employee hire date

Enrollment reason	Enrollment reason date. Select one.	If COBRA, indicate number of months. Select one.	Plan start date
	❍ Same as hire date ❍ Other date_____	❍ 18 months ❍ 29 months ❍ 36 months	

Employee completes the rest of the form

Employee Information
All fields are required

Employee name (last, first)	Area code & phone number	Email address

Mailing address

Enrollment Information
All fields are required

Medical plan choice	Dental plan choice (as applicable)

Note: Please indicate names as you would like them to appear on the ID card. (limit of 26 characters including spaces)

Relationship to employee	Last name	First name	Social Security number – required for any member over age 44
Self			

Date of birth (mm/dd/yyyy)	Gender – select one	Reason – select one	Benefit selection – select all that apply
	❍ Male ❍ Female	❍ Add ❍ Drop	☐ Medical ☐ Dental

Primary language – select one	Race/Ethnicity – select all that apply (optional)	
❍ English ❍ Spanish ❍ Other_____	☐ American Indian/Alaska 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 – required for any member over age 44
Date of birth (mm/dd/yyyy)	Gender – select one ❍ Male ❍ Female	Reason – select one ❍ Add ❍ Drop	Benefit selection – select all that apply ☐ Medical ☐ Dental
Primary language – select one ❍ English ❍ Spanish ❍ Other__________	Race/Ethnicity – select all that apply (optional) ☐ American Indian/Alaska 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 – required for any member over age 44
Date of birth (mm/dd/yyyy)	Gender – select one ❍ Male ❍ Female	Reason – select one ❍ Add ❍ Drop	Benefit selection – select all that apply ☐ Medical ☐ Dental
Primary language – select one ❍ English ❍ Spanish ❍ Other__________	Race/Ethnicity – select all that apply (optional) ☐ American Indian/Alaska 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 – required for any member over age 44
Date of birth (mm/dd/yyyy)	Gender – select one ❍ Male ❍ Female	Reason – select one ❍ Add ❍ Drop	Benefit selection – select all that apply ☐ Medical ☐ Dental
Primary language – select one ❍ English ❍ Spanish ❍ Other__________	Race/Ethnicity – select all that apply (optional) ☐ American Indian/Alaska 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 – required for any member over age 44
Date of birth (mm/dd/yyyy)	Gender – select one ❍ Male ❍ Female	Reason – select one ❍ Add ❍ Drop	Benefit selection – select all that apply ☐ Medical ☐ Dental

Primary language – select one
❍ English
❍ Spanish
❍ Other_____

Race/Ethnicity – select all that apply (optional)
☐ American Indian/Alaska 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 – required for any member over age 44
Date of birth (mm/dd/yyyy)	Gender – select one ❍ Male ❍ Female	Reason – select one ❍ Add ❍ Drop	Benefit selection – select all that apply ☐ Medical ☐ Dental

Primary language – select one
❍ English
❍ Spanish
❍ Other_____

Race/Ethnicity – select all that apply (optional)
☐ American Indian/Alaska Native
☐ Asian
☐ Black/African American
☐ Native Hawaiian/Pacific Islander
☐ Hispanic/Latino
☐ Not Hispanic or Latino
☐ White

Additional dependent information

If any dependent has a different mailing address, please attach that information. Additional information attached? Select one.
❍ Yes
❍ No

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 Dependents** form (see premera.com).

If any applicant has other coverage through another plan, including Medicare or Premera Blue Cross, that will remain in effect when your coverage begins, complete and attach the **Other Coverage Questionnaire** form (see premera.com). If the form is not included, then it is assumed that no other coverage is in effect.

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

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

Employee Signature

In applying for enrollment as indicated on this application, I declare that all 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 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	Print name	
X _____	Title	Date signed

***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 your personal information, 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. 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 change 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.

State of Continuation Coverage

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.

Creditable Coverage

Creditable coverage means, prior or ongoing healthcare coverage including group healthcare coverage, the Federal Employees Health Benefits Plan, the Peace Corps, individual healthcare coverage, student health plans, Medicare, Medicaid, CHAMPUS, Indian Health Service or tribal organization coverage, state high-risk pool coverage, state Children's Health Insurance Programs (CHIP), a public health plan established or maintained by a State or any political subdivision of a State, the U.S. government, a foreign country, that provides health coverage to individuals who are enrolled in the plan If you have any questions about the information included in this notice, please call us at 1-800-722-1471'

Notice of availability and nondiscrimination **800-722-1471 | TTY: 711**

Call for free language assistance services and appropriate auxiliary aids and services.
Llame para obtener servicios gratuitos de asistencia lingüística, y ayudas y servicios auxiliares apropiados.
呼吁提供免费的语言援助服务和适当的辅助设备及服务。
呼籲提供免費的語言援助服務和適當的輔助設備及服務。
Gọi cho các dịch vụ hỗ trợ ngôn ngữ miễn phí và các hỗ trợ và dịch vụ phụ trợ thích hợp.
무료 언어 지원 서비스와 적절한 보조 도구 및 서비스를 신청하십시오.
Звоните для получения бесплатных услуг по переводу и других вспомогательных средств и услуг.
Tumawag para sa mga libreng serbisyo ng tulong sa wika at angkop na mga karagdagang tulong at serbisyo.
Звертайтесь за безкоштовною мовною підтримкою та відповідними додатковими послугами.
សូមហៅទូរសព្ទទៅសេវាជំនួយភាសាដោយឥតគិតថ្លៃ ព្រមទាំងសេវាកម្ម និងជំនួយចាំបាច់ដែលសមរម្យផ្សេងៗ។
無料言語支援サービスと適切な補助器具及びサービスをお求めください。
ለነፃ የቋንቋ እርዳታ አገልግሎቶች እና ተገቢ ድጋፍ ሰጪ አጋዥ መሳሪያዎችን እና አገልግሎቶችን ለማግኘት በስልክ ቁጥር
Tajaajiloota deeggarsa afaan bilisaa fi gargaarsaa fi tajaajiloota barbaachisaa ta'an argachuuf bilbilaa.
મુફત ભાષા સહાયિતા સેવાવાં અને ઉચિત સહાયિક ચીજાં અને સેવાવાં વાસતે કાલ કરો।
Fordern Sie kostenlose Sprachunterstützungsdienste und geeignete Hilfsmittel und Dienstleistungen an.
ໂທເພື່ອຮັບການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ ແລະ ການບໍລິການ ແລະ ການຊ່ວຍເຫຼືອພິເສດທີ່ເໝາະສົມແບບບໍ່ເສຍຄ່າ.
Rele pou w jwenn sèvis asistans lengwistik gratis ak èd epi sèvis oksilyè ki apwopriye.
Appelez pour obtenir des services gratuits d'assistance linguistique et des aides et services auxiliaires appropriés.
Zadzwoń, aby uzyskać bezpłatną pomoc językową oraz odpowiednie wsparcie i usługi pomocnicze.
Ligue para serviços gratuitos de assistência linguística e auxiliares e serviços auxiliares adequados.
Chiama per i servizi di assistenza linguistica gratuiti e per gli ausili e i servizi ausiliari appropriati.
اتصل للحصول على خدمات المساعدة اللغوية المجانية والمساعدات والخدمات المناسبة.
برای خدمات کمک زبانی رایگان و کمک‌ها و خدمات امدادی مقتضی، تماس بگیرید.

Discrimination is against the law. Premera Blue Cross (Premera) complies with applicable Federal and Washington state civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex, including sex characteristics, intersex traits, pregnancy or related conditions, sexual orientation, gender identity, and sex stereotypes. Premera does not exclude people or treat them less favorably because of race, color, national origin, age, disability, sex, sexual orientation, or gender identity. Premera provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services 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 provides free language assistance services to people whose primary language is not English, which may include qualified interpreters and information written in other languages. If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, contact our Civil Rights Coordinator. If you believe that Premera has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity, you can file a grievance with: Civil Rights Coordinator — Complaints and Appeals, PO Box 91102, Seattle, WA 98111, Toll free: 855-332-4535, TTY: 711, Fax: 425-918-5592, Email AppealsDepartmentInquiries@Premera.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our 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.

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