

Member Enrollment and Change Application

Employer completes this section. All fields are required.

Group information			
Group number	Group name	Employee class/subgroup (if multiple)	Employee hire date MM/DD/YYYY _____
Enrollment reason	Enrollment reason date – select one ☐ Same as hire date ☐ Other date _____	If COBRA, indicate number of months -select one ☐ 18 months ☐ 29 months ☐ 36 months	Plan start date MM/DD/YYYY _____

Employee completes the rest of the form. All fields are required.

Enrollment information					
Medical plan choice			Dental plan choice (as applicable)		
Employee information Provide names as you would like them to appear on the ID card. Limit of 26 characters including spaces.					
Employee last name		Employee first name		Phone – include area code	Email address
Mailing address				City	State Zip code
Social Security number – required	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 ☐ Hispanic/Latino ☐ Asian ☐ Not Hispanic or Latino ☐ Black/African American ☐ White ☐ Native Hawaiian/Pacific Islander			

Dependent information Provide 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
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 ☐ Hispanic/Latino ☐ Asian ☐ Not Hispanic or Latino ☐ Black/African American ☐ White ☐ Native Hawaiian/Pacific Islander		

Relationship to employee	Last name	First name	Social Security number – required
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 ☐ Hispanic/Latino ☐ Asian ☐ Not Hispanic or Latino ☐ Black/African American ☐ White ☐ Native Hawaiian/Pacific Islander		

Relationship to employee	Last name	First name	Social Security number – required
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 ☐ Hispanic/Latino ☐ Asian ☐ Not Hispanic or Latino ☐ Black/African American ☐ White ☐ Native Hawaiian/Pacific Islander		

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

Relationship to employee	Last name	First name	Social Security number – required
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 ☐ Hispanic/Latino ☐ Asian ☐ Not Hispanic or Latino ☐ Black/African American ☐ White ☐ Native Hawaiian/Pacific Islander	

Additional dependent information

If any dependent has a different mailing address, 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, complete and attach the **Request for Certification of Disabled Dependents** form which can be found at premera.com.

If any applicant has other current health coverage, including Medicare or Premera Blue Cross Blue Shield of Alaska, remaining in effect when your Premera Blue Cross Blue Shield of Alaska coverage begins complete and attach the **Other Coverage Questionnaire** form which can be found at premera.com. If the form is not included, then it is assumed that no other coverage is in effect.

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 _____	Print title
	Date signed MM/DD/YYYY

Note: A person who, with intent to injure, defraud, or deceive, knowingly makes a false or fraudulent statement or representation in or with reference to an application for insurance, may be prosecuted under state law.

Notices

Premera Privacy Policy

We may collect, use, or disclose personal information about you, such as health information, your address, telephone number or Social Security number. We may exchange this information with healthcare providers, insurance companies, or other sources to conduct our routine business operations. Examples are deciding if you qualify for coverage; paying claims; coordinating benefits with other healthcare plans; or conducting care management, case management, or quality reviews. We may also collect, use or release your personal information 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 approval to release such information.

You have the right to ask to look at or change your records retained by us. To view or print copies of our detailed Privacy Notice and other forms, please visit our web site 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 (60 days if the prior coverage was through Medicaid or CHIP). 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 marriage, birth, adoption, or placement for adoption, 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.

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 **1-800-508-4722**.