GroupHealth.

12401 E. Marginal S., Tukwila, WA 98168
P.O. Box 34750, Seattle, WA 98124-9745

Employee enrollment and change form

EMPLOYER: PLEASE COMPLETE THIS SECTION

Coverage effective date _____

Group name _____

*Group number _____

Choose one: ☐ **Group Health Cooperative** ☐ **Group Health Options, Inc.**

Original date of hire ____/____/____

Date of rehire ____/____/____

Date transferred from part time (p/t) to full time (f/t) ____/____/____

Hours worked per week _____

If retired, date of retirement ____/____/____

Choose one:
- ☐ Open enrollment
- ☐ New employee
- ☐ Address/name change
- ☐ Add dependent(s)
- ☐ Remove coverage
  ___ Subscriber ___ Dependent(s)

Date processed __/__/__ by _____

☐ **Transfer to COBRA**
Start date _____
- ☐ 18 months
- ☐ 36 months

EMPLOYEE: COMPLETE THE FOLLOWING. PLEASE PRINT.

Employee name _____
(Last name) (First name) (M.I.)

Marital status: ☐ Single ☐ Married

Date married____/____/____

☐ State-registered domestic partnership

Resident address _____
(Street) (City) (State) (ZIP)

Work phone ( )_____

Mailing address (if different) _____

Home phone ( )_____

Billing address (if different) _____

Employee Medicare claim # _____ Former name of applicant or spouse _____

Health plan choice: *If more than one health plan is offered, please write in your choice, including the group number.*

Health plan _____ *Group number _____

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.

FOR HEALTH PLAN INTERNAL USE ONLY	CHECK ONE ADD	CHECK ONE REMOVE	PLEASE PRINT LAST NAME FIRST NAME M.I.	SOCIAL SECURITY NUMBER	MALE/ FEMALE	BIRTHDATE (MM/DD/YY)	RELATIONSHIP TO EMPLOYEE
			SELF				
			SPOUSE/DEPENDENT				
			DEPENDENT				
			DEPENDENT				
			DEPENDENT				

*Group number should match health plan choice, if selected by employee in section above.

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Employee enrollment and change form

EMPLOYEE: COMPLETE THE FOLLOWING. PLEASE PRINT.

Please list names of any **dependents who are Medicare-eligible and their Medicare number:**

NAME (FIRST AND LAST)	MEDICARE NUMBER
SPOUSE	
DEPENDENT	
DEPENDENT	

Additional health benefits information

Other coverage (that is not Group Health Cooperative or Group Health Options, Inc.)_____

Who is the subscriber under this plan? _____

What is their social security or policy number with this plan? _____ Attach any certificate of creditable coverage letters to this form.

Your contract may contain coverage exclusions for Pre-Existing Conditions (PEC). These exclusions could be fully or partially waived based on prior or current coverage. Review this section carefully and complete the information requested for both you and your dependents to assure proper processing of your claims.

NAME (FIRST AND LAST)	CURRENT OR PREVIOUS CARRIER (INCLUDE PHONE NUMBER)	COBRA	DATE COVERAGE BEGAN (MM/DD/YY)	DATE COVERAGE ENDED (MM/DD/YY)
		☐ Yes ☐ No		
		☐ Yes ☐ No		
		☐ Yes ☐ No		
		☐ Yes ☐ No		
		☐ Yes ☐ No		
		☐ Yes ☐ No		

(Signature of employee) **(Date signed)**

Please retain a copy for your records.

Coverage provided by Group Health Cooperative, registered in Washington state, or Group Health Options, Inc., registered in Washington and Idaho.