



Combined insurance enrollment form

Complete entire form to enroll or make changes.

Employer - Please note that failure to fully complete this form may result in this form being returned to you and will delay the processing of the form. Please proof this form carefully.

Employer Employer to complete this section and send completed form to AWC at benefitinfo@awcnet.org or fax to 360.753.0149 or mail to 1076 Franklin Street SE, Olympia, WA 98501-1346

Employer name _____ Date of hire _____ Effective date of change _____

City of DuPont

Employee's occupation _____ Class/bargaining unit _____

Salary Annual \$ _____ Monthly \$ _____ Weekly \$ _____ Hourly \$ _____

Enrollment

- New hire
- New group
- Open enrollment January 1

Changes

Has there been a change that affects your insurance? Check all the changes that apply to you and complete the entire form.

- Name Address Marriage Domestic Partnership Divorce Legal separation Beneficiary
- Other (be specific) _____
- Add dependent (check reason) Marriage Domestic Partnership Newborn
 - Other reason (be specific) _____
- Drop dependent Comments _____

Employee

Please print legibly in blue or black ink.

SSN _____ Employee Name (last, first, initial) _____ Date of birth _____ Gender _____

Single Married Date married: _____ Divorced Date divorced: _____

Domestic partnership Date met DP criteria: _____ Partnership termination Date terminated: _____

Home/ mailing address _____ Phone (with area code) _____

City _____ State _____ Zip _____ Email address _____

Type of coverage requested (check all that apply): Medical Dental Vision Life Long-term disability EAP
Carriers and specific plans are listed on the back of this form.

Are you adding this coverage due to a recent loss of coverage? Yes No If yes, complete below.

Name of other insurance company _____ Type of insurance (medical, dental, etc.) _____ Group# _____ Policy # _____

Effective date _____ Termination date _____

Insured's SSN _____ Name (last, first, initial) _____

Spouse/ Domestic Partner

Please list spouse/domestic partner who should be covered on your insurance. Leaving them off will terminate coverage. Proof of dependency will be requested, including, but not limited to, marriage certificate, affidavit of marriage/domestic partnership, joint ownership documents.

SSN _____ Spouse/DP name (last, first, initial) _____ Date of birth _____ Gender _____

Type of insurance requested: Medical Dental Vision Life

Are you adding this coverage due to a recent loss of coverage? Yes No If yes, complete below.

Name of insurance company _____ Type of insurance (medical, dental, etc.) _____ Group# _____ Policy # _____

Effective date _____ Termination date _____ Phone # _____

Dependents

Please list all dependents that should be covered on your insurance. Leaving them off the form will terminate coverage. Proof of dependency will be requested, but not limited to, birth certificate, adoption papers. **Medical, dental & vision:** A dependent is a child, stepchild or adopted child; less than age 26 or prior to age 26 was incapable of self-support due to developmental disabilities or physical handicap (proof of incapacity required). **Life:** A dependent is a child, stepchild or adopted child from birth but less than age 26.

Please check all appropriate boxes and fill in the appropriate blanks.
For additional dependents, please fill out additional forms and alter "Dependent # ____."

Dependent #1

Name (last, first, middle initial) _____

SSN _____

Gender _____ Date of birth _____ Relationship to insured _____

Type of insurance requested:

Medical Dental Vision Life

Are you adding this coverage due to a recent loss of coverage? Yes No

If yes, name of other insurance company & type (medical, dental, etc.) _____

Name of insured (last, first, initial) _____ SSN of insured _____

Group/policy # _____ Effective date _____ Termination date _____

Does he/she live with you? Yes No

If no, name of person with whom he/she resides

Last, first, initial _____

SSN _____

Home address _____ Home phone _____

City _____ State _____ Zip _____

Dependent #2

Name (last, first, middle initial) _____

SSN _____

Gender _____ Date of birth _____ Relationship to insured _____

Type of insurance requested:

Medical Dental Vision Life

Are you adding this coverage due to a recent loss of coverage? Yes No

If yes, name of other insurance company & type (medical, dental, etc.) _____

Name of insured (last, first, initial) _____ SSN of insured _____

Group/policy # _____ Effective date _____ Termination date _____

Does he/she live with you? Yes No

If no, name of person with whom he/she resides

Last, first, initial _____

SSN _____

Home address _____ Home phone _____

City _____ State _____ Zip _____

Dependents

Please list all dependents that should be covered on your insurance. Leaving them off the form will terminate coverage. Proof of dependency will be requested, but not limited to, birth certificate, adoption papers. **Medical, dental & vision:** A dependent is a child, stepchild or adopted child; less than age 26 or prior to age 26 was incapable of self-support due to developmental disabilities or physical handicap (proof of incapacity required). **Life:** A dependent is a child, stepchild or adopted child from birth but less than age 26.

Please check all appropriate boxes and fill in the appropriate blanks.
For additional dependents, please fill out additional forms and alter "Dependent # ____."

Dependent #3

Name (last, first, middle initial) _____

SSN _____

Gender _____ Date of birth _____ Relationship to insured _____

Type of insurance requested:

Medical Dental Vision Life

Are you adding this coverage due to a recent loss of coverage? Yes No

If yes, name of other insurance company & type (medical, dental, etc.) _____

Name of insured (last, first, initial) _____ SSN of insured _____

Group/policy # _____ Effective date _____ Termination date _____

Does he/she live with you? Yes No

If no, name of person with whom he/she resides

Last, first, initial _____

SSN _____

Home address _____ Home phone _____

City _____ State _____ Zip _____

Dependent #4

Name (last, first, middle initial) _____

SSN _____

Gender _____ Date of birth _____ Relationship to insured _____

Type of insurance requested:

Medical Dental Vision Life

Are you adding this coverage due to a recent loss of coverage? Yes No

If yes, name of other insurance company & type (medical, dental, etc.) _____

Name of insured (last, first, initial) _____ SSN of insured _____

Group/policy # _____ Effective date _____ Termination date _____

Does he/she live with you? Yes No

If no, name of person with whom he/she resides

Last, first, initial _____

SSN _____

Home address _____ Home phone _____

City _____ State _____ Zip _____

Life insurance beneficiaries

For life insurance policies as underwritten by Standard Life Insurance only. Please note that in community property states, including Washington, the spouse has legal right to 50% of the benefits, in the event of the employee's death.

Name of primary beneficiary (last, first, initial)

SSN

Address

City State Zip

Relationship to insured Percent of proceeds

Name of contingent beneficiary #1 (last, first, initial)

SSN

Address

City State Zip

Relationship to insured Percent of proceeds

Name of contingent beneficiary #2 (last, first, initial)

SSN

Address

City State Zip

Relationship to insured Percent of proceeds

Name of contingent beneficiary #3 (last, first, initial)

SSN

Address

City State Zip

Relationship to insured Percent of proceeds

Your signature is required

I hereby verify that all of the information specified on this form is accurate and complete. By signing below, I have authorized the release of information for myself and my dependents listed on this form to the carriers (listed on back of this form) that cover me and my family members (if applicable). Please note that failure to fully complete this enrollment form may result in this form being returned to you and will delay processing of the form.

I hereby apply for coverage under the contract between the respective insurance company and my employer and AWC, and I agree with the terms of the contract. I also apply for the same coverage for my spouse/ domestic partner and/ or dependents listed on this application. I certify that my dependents and I meet all the eligibility criteria set forth in the outline or benefits and/or the Contract.

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 acknowledgment does not apply to obtaining information regarding psychotherapy notes. A separate authorization will be used for psychotherapy notes.

It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purposes of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

**For more information about such uses and disclosures, including uses and disclosures required by law, please refer to the individual insurance carrier Consumer Privacy Notices by contacting the carrier directly.*

Signature _____

Date _____

Select benefits on the next page.

Employee plan enrollment (Please check all that apply.)

Medical



1800 Ninth Ave
Seattle, WA 98101

- Regence BlueShield**
 High Deductible Health Plan



601 Union St., Suite 3100
Seattle, WA 98101

- Kaiser Foundation Health
Plan of Washington
Options, Inc.**
 Access PPO

- Decline medical coverage**

Vision



3333 Quality Drive
Rancho Cordova, CA 95670

**Vision Service Plan
(071038Z2)**

- No copay
 Second pair rider

Employee Assistance Program



NBC Tower
455 N. Cityfront Plaza Drive
Chicago, IL 60611-5322

ComPsych

- 1-3 sessions - Included
when enrolled on any
AWC Trust plan

Dental



Delta Dental of Washington

9706 Fourth Ave NE
Seattle, WA 98115
**Delta Dental of Washington
Basic (0177)**

- Plan E

Orthodontia

- Option II



**Willamette
Dental Group**

6950 NE Campus Way
Hillsboro, OR 97124

**Willamette Dental of
Washington, Inc.**

- \$10 copay

Life



1100 SW 6th Ave
Portland, OR 97204

Standard Insurance Company

- Basic life \$ _____

- Employee additional life
\$ _____

Note: EOI form required if
over \$80,000.

- Spouse additional life
\$ _____

Note: Cannot exceed 50% of
employee additional life.

EOI required, if over
\$20,000.

Long-term disability



1100 SW 6th Ave
Portland, OR 97204

Standard Insurance Company

- 90-day: 60% benefit