



P.O. Box 34750
Seattle Washington 98124-9745

EMPLOYEE ENROLLMENT and CHANGE FORM

EMPLOYER: PLEASE COMPLETE THIS SECTION

Coverage Effective Date _____ Original Date of Hire / / **Choose one:**
 Date of Rehire / / Open Enrollment New Employee Transfer to COBRA
 Date Transferred From / / Address/Name Change Add Dependent(s) Start Date _____
 Part (P/T) to Full Time (F/T) / / Remove Coverage Add Dependent(s) 18 months
 Hours Worked Per Week _____ Subscriber Dependent(s) 36 months
 If Retired, Date of Retirement / / Date processed _____ By _____

Group Name _____

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

EMPLOYEE: COMPLETE THE FOLLOWING NON-SHADED AREAS. PLEASE PRINT.

Employee Name _____ (Last Name) _____ (First Name) _____ (M.I.) Marital Status: Married Single Date Married / /

Mailing Address _____ Home Phone (_____) _____

Resident Address _____ (Street) _____ (City) _____ (State) _____ (Zip) Work Phone (_____) _____

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 _____

For Health Plan Internal Use Only	CHECK ONE		PLEASE PRINT			Social Security Number	Sex	Birthdate (mm/dd/yy)	Relationship to Employee	List Personal Physician Name/Medical Center	Current Patient?	
	Add	Remove	Last Name	First Name	M.I.						Yes	No
			SELF						SELF			
			DEPENDENT									
			DEPENDENT									
			DEPENDENT									
			DEPENDENT									
			DEPENDENT									

DEPENDENT ELIGIBILITY INFORMATION *Please list names of married dependents:*

1. _____ (Last Name) _____ (First Name) _____ (M.I.) 2. _____ (Last Name) _____ (First Name) _____ (M.I.)

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

1. Spouse Medicare Claim # _____ 2. Dependent Name _____ Medicare Claim # _____

ADDITIONAL HEALTH BENEFITS INFORMATION

Other insurance (that is *not* a Group Health, Options, or Alliant health plan): _____

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 the back of this form.**

(Signature of Employee)

(Date Signed)

Please notify us in writing of any changes to address or family status.
 WHITE COPY – SEND TO HEALTH PLAN YELLOW COPY – EMPLOYER RETAIN