



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
 Date Transferred From / / Address/Name Change Add Dependent(s)
 Part (P/T) to Full Time (F/T) / / Remove Coverage
 Hours Worked Per Week _____ Subscriber Dependent(s)
 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.*

Transfer to COBRA
 Start Date _____
 18 months
 36 months

EMPLOYEE: COMPLETE THE FOLLOWING. PLEASE PRINT.

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

Mailing Address _____ Home Phone (_____) _____
(Street) (City) (State) (Zip)

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

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 _____

Coverage provided by
 Group Health Cooperative
 or Group Health Options, Inc.

For Health Plan Internal Use Only	CHECK ONE		PLEASE PRINT			Social Security Number	Sex	Birthdate (mm/dd/yy)	Relationship to Employee
	Add	Remove	Last Name	First Name	M.I.				
			SELF						SELF
			DEPENDENT						
			DEPENDENT						
			DEPENDENT						
			DEPENDENT						
			DEPENDENT						

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

1. _____ 2. _____
(Last Name) (First Name) (M.I.) (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 _____ 3. Medicare Claim # _____

ADDITIONAL HEALTH BENEFITS INFORMATION

Other insurance (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 the back of this form.**

(Signature of Employee)

(Date Signed)