



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 _____	Original Date of Hire ____/____/____	<b>Choose one:</b> <input type="checkbox"/> Open Enrollment <input type="checkbox"/> New Employee <input type="checkbox"/> Address/Name Change <input type="checkbox"/> Add Dependent(s) <input type="checkbox"/> Remove Coverage ___ Subscriber    ___ Dependent(s) Date Processed _____ By _____	<input type="checkbox"/> <b>Transfer to COBRA</b> Start Date _____ <input type="checkbox"/> 18 months <input type="checkbox"/> 36 months
Group Name _____	Date of Rehire ____/____/____		
Group Number _____	Date Transferred From Part (P/T) to Full Time (F/T) ____/____/____		
<i>*Group number should match health plan choice, if selected by employee in section below.</i>	Hours Worked Per Week ____/____/____		
<b>Choose one:</b> <input type="checkbox"/> <b>Group Health Cooperative</b> <input type="checkbox"/> <b>Group Health Options, Inc.</b>	If Retired, Date of Retirement ____/____/____		

## EMPLOYEE: COMPLETE THE FOLLOWING. PLEASE PRINT.

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

Mailing Address \_\_\_\_\_ Home Phone (    ) \_\_\_\_\_

Resident Address \_\_\_\_\_ (Street) \_\_\_\_\_ (City) \_\_\_\_\_ (State) \_\_\_\_\_ (Zip)      Work Phone (    ) \_\_\_\_\_

Employee Medicare Claim # \_\_\_\_\_ Former Name of Applicant or Spouse \_\_\_\_\_

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.

### 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 LAST NAME	FIRST NAME	M.I.	SOCIAL SECURITY NUMBER	MALE/ FEMALE	BIRTHDATE (MM/DD/YY)	RELATIONSHIP TO EMPLOYEE
	ADD	REMOVE							
			SELF						
			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 \_\_\_\_\_ 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)**

Please retain a copy for your records