

CITY OF RENTON

1055 South Grady Way Renton, WA 98057

PLEASE PRINT CLEARLY

▶▶▶ EMPLOYER TO COMPLETE SHADED SECTION

Group Policy Numbers: HEALTHCARE MANAGEMENT ADMINISTRATORS CITY OF RENTON #4034	Employment Data: Date of Hire _____/_____/_____ Date of Rehire _____/_____/_____ Effective Date _____/_____/_____	Effective Date: <input type="checkbox"/> Open Enrollment _____/_____/_____ <input type="checkbox"/> New Employee _____/_____/_____ <input type="checkbox"/> Re-instatement _____/_____/_____ <input type="checkbox"/> Change in Status _____/_____/_____	Change Form For: <input type="checkbox"/> Reprint Cards <input type="checkbox"/> Add Dependent(s) <input type="checkbox"/> Name Change <input type="checkbox"/> Drop Dependent(s) <input type="checkbox"/> Address Change <input type="checkbox"/> Cancel Employee Effective Date of Change: _____/_____/_____
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▶▶▶ EMPLOYEE: PLEASE MAKE YOUR BENEFIT SELECTIONS HERE

DIVISION: <u>check those that apply</u> <input type="checkbox"/> AFSCME <input type="checkbox"/> Council/Mayor - elected <input type="checkbox"/> Firefighters 864 <input type="checkbox"/> Non-Union/Mgmt <input type="checkbox"/> Police Guild – uniformed <input type="checkbox"/> LEOFF I Active <input type="checkbox"/> Non-union/clerical <input type="checkbox"/> Non-Uniform Police <input type="checkbox"/> LEOFF I Retired <input type="checkbox"/> LOCATION _____ <input type="checkbox"/> OTHER _____	COVERAGE/PARTICIPANT ELECTIONS: MEDICAL/Rx/VISION DENTAL <input type="checkbox"/> EMPLOYEE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> SPOUSE <input type="checkbox"/> DOMESTIC PARTNER* <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> CHILD(REN) <input type="checkbox"/> <input type="checkbox"/>
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▶▶▶ EMPLOYEE: PLEASE COMPLETE THIS INFORMATION ABOUT YOURSELF

SOCIAL SECURITY NUMBER	LAST NAME	FIRST NAME	MI	DATE OF BIRTH	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	<input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED
HOME MAILING ADDRESS				HOME PHONE NUMBER	EMAIL ADDRESS	
CITY		STATE	ZIP	WORK PHONE NUMBER	JOB TITLE OR OCCUPATION	

▶▶▶ EMPLOYEE: PLEASE COMPLETE THIS INFORMATION ABOUT DEPENDENTS WHO WILL BE ENROLLED ON MEDICAL/ DENTAL BENEFITS

ADD	DROP	CHECK ALL THAT APPLY	LAST NAME, FIRST NAME	SOCIAL SECURITY NUMBER (REQUIRED FIELD)	DATE OF BIRTH	GENDER
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> SP / DP *				<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> CHILD				<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> CHILD				<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> CHILD				<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> CHILD				<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE

Are any of the dependent children listed above ELIGIBLE for coverage through their own employer's plan or through their spouse's employer's insurance plan? Yes No
 If yes, please list the names of those dependents who are eligible for that coverage here: _____

* If enrolling a Domestic Partner you will also need to submit an Affidavit of Domestic Partnership (available from Human Resources)

▶▶▶ DISABLED DEPENDENT ELIGIBILITY

List dependent who is developmentally disabled or physically handicapped who is over age 25:

Name: _____ Medical documentation must be submitted within 31 days of the effective date of coverage

**** Signature Required On Back of Form ****

▶▶▶ **EMPLOYEE: PLEASE COMPLETE THE FOLLOWING COORDINATION OF BENEFITS INFORMATION**

Currently do you, your spouse or any of your children have coverage through another insurance plan? Yes No

If yes, please complete the following:

Marital Status: Single Married _____ Widowed Legally Separated Divorced
Name of Spouse/Domestic Partner

If divorced, is there a court order for provision of the child? Yes No If Yes, please attach a copy of the court decree.

Per court decree: Who has custody of child? _____ Who provides insurance for child? _____

Please list the full name of the child(ren) _____

Please list both the natural parents name and date of birth:

Natural Father _____ / DOB _____ Natural Mother _____ / DOB _____

List all family member(s), including yourself, who are included on this enrollment form and are currently covered through another plan.

Name of covered members:	Type of Coverage: (M)edical (D)ental (V)ision	Type of Policy: (G)roup (I)ndividual	Effective date of coverage: ____/____/____	Carrier Name:
_____	_____	_____	____/____/____	_____
_____	_____	_____	____/____/____	_____
_____	_____	_____	____/____/____	_____

Provide the following information on the carriers listed above:

Carrier Name: _____ Policy Number: _____

Street Address: _____ City: _____ State _____ Zip _____

Carrier phone #: _____ Subscriber's Name: _____ Social Security Number: _____

Date of birth: _____ Employer's Name and Address (if group coverage) _____

Is Employee, Spouse/Domestic Partner covered under this medical plan eligible for Medicare benefits? Yes No

If Yes, enter Date of Eligibility for Medicare Part A _____ Date of Eligibility for Medicare Part B _____ Social Security No. _____

▶▶▶ **RELEASE AND AUTHORIZATION**

I certify that the above listed information is correct and that I am enrolling only eligible dependents as defined in the Plan Document. *By signing this form, I attest that all dependent children listed for coverage are under age 26 and are not eligible for coverage through their own or their spouse's employer.* I understand that all entitlements to benefits are void, and coverage may be canceled or modified retroactively to its effective date, if I have made intentionally false or misleading statements or answers on behalf of myself or any family members. I authorize any person or institution providing care or services, or any organization in possession of insurance benefit information to release any and all information pertaining to the care or benefits provided to me or my dependents to Healthcare Management Administrators or its designated agent. I acknowledge and understand that my health plan may request or disclose health information about me or my dependents (persons who are listed for benefits coverage on the enrollment form) from time to time 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: 1) A physician, dentist, pharmacist or other physical or behavioral health care practitioner; 2) A clinic, hospital, long term care or other medical facility; 3) Any other institution providing care, treatment, consultation, pharmaceuticals or supplies; or 4) 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 acknowledgement does not apply to obtaining information regarding psychotherapy notes. A separate authorization will be used for psychotherapy notes.

* For more information about such uses and disclosures, including uses and disclosures required by law, please refer to the Privacy Notice. A copy is available upon request.

PRINT EMPLOYEE NAME _____ ▶▶▶ SIGNATURE _____ DATE _____