



# 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 \_\_\_\_\_

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  Divorced Date divorced: \_\_\_\_\_
- Partnership termination Partnership termination date: \_\_\_\_\_

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 \_\_\_\_\_

Date married: \_\_\_\_\_ Date met DP criteria: \_\_\_\_\_

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

Mailing 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

Mailing 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

### 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

#### 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

Mailing address Home phone

City State Zip

Does he/she live with you?  Yes  No

Mailing 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 \_\_\_\_\_ Date of birth \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Relationship to insured \_\_\_\_\_ Percent of proceeds \_\_\_\_\_

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

SSN \_\_\_\_\_ Date of birth \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Relationship to insured \_\_\_\_\_ Percent of proceeds \_\_\_\_\_

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

SSN \_\_\_\_\_ Date of birth \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Relationship to insured \_\_\_\_\_ Percent of proceeds \_\_\_\_\_

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

SSN \_\_\_\_\_ Date of birth \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Relationship to insured \_\_\_\_\_ Percent of proceeds \_\_\_\_\_

## Your signature is required

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

By signing below, I represent the following:

- I am applying for the selected coverage(s) for myself and, if applicable, for my family members who are listed on this form.
- My family members and I meet all of the eligibility criteria to apply for such coverage(s), and I understand that proof of dependency will be requested for enrollment of my family members.
- All information I have provided on this form is accurate and complete.
- I understand that it is a crime to knowingly provide false, incomplete, or misleading information for purposes of defrauding the Trust, a health plan, or an insurance company, with penalties including denial of coverage, fines, and/or imprisonment.

I authorize the release of information about me and my family members to the insurance companies listed on back of this form for purposes of enrolling and receiving benefits under my selected coverage(s).

If I am enrolling in health plan coverage, I acknowledge and understand that the health plan may use or disclose personal health information about me or my enrolled family members to the extent permitted by law, including to facilitate our health care treatments and payments and to otherwise support health plan operations and administration. I understand that I can learn more about how the health plan may use or disclose personal health information by reviewing the Notice of Privacy Practices issued by the health plan. I understand that I can request to receive a copy of this Notice at any time.

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**
  - AWC HealthFirst® 250**
  - AWC HealthFirst® 500**
  - High Deductible Health Plan**
  - Accountable Health Network Plan**
    - UW Medicine
    - Eastside Health Network
    - MultiCare
    - CHI Franciscan/  
Virginia Mason



601 Union St., Suite 3100  
Seattle, WA 98101

- Kaiser Foundation Health Plan of Washington**
  - \$200 Deductible Plan**
  - \$500 Deductible Plan**
  - High Deductible Health Plan**

- Decline medical coverage**

## Vision



3333 Quality Drive  
Rancho Cordova, CA 95670  
Vision Service Plan (071038Z2)

- No copay
- \$10 copay
- \$25 copay**
- \$10/\$15 copay plan
- Second pair rider**



528 E Spokane Falls Blvd,  
Suite 301  
Spokane, WA 99202

- Asuris Northwest Health**
  - AWC HealthFirst® 250**
  - AWC HealthFirst® 500**
  - High Deductible Health Plan**



601 Union St., Suite 3100  
Seattle, WA 98101

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

## Employee Assistance Program



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

- 1-3 sessions - Included when enrolled on any AWC Trust plan
- 1-5 Buy-up
- 1-8 Buy-up**

## Dental



Delta Dental of Washington  
400 Fairview Ave N  
Seattle, WA 98109-5371  
**Delta Dental of Washington Basic (0177)**

- Plan A
- Plan B
- Plan C
- Plan D
- Plan E
- Plan F**
- Plan G
- Plan J

### Orthodontia

- Option I
- Option II
- Option III
- Option IV
- Option V



6950 NE Campus Way  
Hillsboro, OR 97124  
**Willamette Dental of Washington, Inc.**

- \$10 copay
- \$15 copay

## Life



1100 SW 6th Ave  
Portland, OR 97204  
**Standard Insurance Company**

- Basic life w/AD&D**  
\$ \_\_\_\_\_
- Dependent life**
  - Plan option 1
  - Plan option 2
  - Plan option 3
  - Plan option 4
- Employee additional life**  
\$ \_\_\_\_\_  
Note: EOI form required if over \$80,000.
- Spouse additional life**  
\$ \_\_\_\_\_  
Note: EOI form required if over \$20,000.

## Long-term disability



1100 SW 6th Ave  
Portland, OR 97204  
**Standard Insurance Company**

- 90-day: 60% benefit
- 90-day: 67% benefit**
- 180-day: 60% benefit
- 180-day: 67% benefit