



LEOFF

Health & Welfare Trust

LEOFF Health & Welfare Trust Office

4407 N. Division, Suite 516

Spokane, WA 99207

Phone Number: 509-484-2388

MEMBER ENROLLMENT AND CHANGE APPLICATION

| 1. GROUP INFORMATION (to be completed by the group) | | | | | | | | | | | | | |
|---|--------------------------|--------------------------|-----------------------|--|--|--------------------------------|---|--|--------------------------|--------------------------|---------------------------|-------|-----|
| Group ID | | Group name | | | <input type="checkbox"/> New <input type="checkbox"/> Change | | Reason | | | Date of event / / | | | |
| Employee class (if applicable) | | Employee job title | | | Employee date of hire / / | | Date employee entered eligible class <input type="checkbox"/> Same as hire date <input type="checkbox"/> Other date / / | | | Effective date / / | | | |
| If COBRA, indicate number of months eligible for coverage: <input type="checkbox"/> 18 months <input type="checkbox"/> 29 months <input type="checkbox"/> 36 months | | | | | If State Continuation (COC), eligible period of coverage cannot exceed 3 months. | | | | | | | | |
| 2. EMPLOYEE INFORMATION (employee to complete sections 2 through 4) | | | | | | | | | | | | | |
| Employee name (Last) | | | Employee name (First) | | | Employee name (MI) | <input type="checkbox"/> Married <input type="checkbox"/> Unmarried | | Daytime phone () | | E-mail address (Required) | | |
| Home address | | | City | State | | ZIP | | Mailing address (if different than home address) | | | City | State | ZIP |
| 3. ENROLLMENT INFORMATION | | | | | | | | | | | | | |
| Medical choice | | Dental choice | | NOTE: In order for dependents to qualify for a benefit selection, the employee must select the same benefit. <i>Please indicate each member's name as you would like it to appear on the ID card. ID card names are limited to 26 characters and spaces.</i> | | | | | | | | | |
| Add | Drop | Relationship to Employee | Last Name | First Name | MI | Social Security No. | Date of Birth | Gender | | Benefit Selection | | | |
| | | | | | | | | Male | Female | Medical | Dental | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Self | | | | | / / | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | |
| <input type="checkbox"/> | <input type="checkbox"/> | | | | | | / / | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | |
| <input type="checkbox"/> | <input type="checkbox"/> | | | | | | / / | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | |
| <input type="checkbox"/> | <input type="checkbox"/> | | | | | | / / | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | |
| <input type="checkbox"/> | <input type="checkbox"/> | | | | | | / / | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | |
| <input type="checkbox"/> | <input type="checkbox"/> | | | | | | / / | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | |
| Does a dependent have a different mailing address? <input type="checkbox"/> No <input type="checkbox"/> Yes, complete the following: Dependent's Name _____ | | | | | | | | | | | | | |
| Dependent's mailing address _____ | | | | | City _____ | | State _____ | | ZIP _____ | | | | |
| Is any child over the dependent age limit applying for coverage due to disability? <input type="checkbox"/> No <input type="checkbox"/> Yes, complete and attach the <i>Request for Certification of Disabled Dependent</i> form. | | | | | | | | | | | | | |
| Will any applicant have other current health coverage including Medicare or LEOFF Trust, which will remain in effect when your coverage begins? <input type="checkbox"/> No <input type="checkbox"/> Yes, please complete and attach the <i>Other Coverage Questionnaire</i> form. | | | | | | | | | | | | | |
| 4. EMPLOYEE SIGNATURE | | | | | | | | | | | | | |
| In applying for enrollment as indicated on this application, I declare that to the best of my knowledge, all of the information on this form is true and complete, and all of the persons for whom I am requesting enrollment are eligible for coverage. I have also read and understand the provisions as stated on the reverse side. The changes on this form supersede all previous forms submitted. | | | | | | | | | | | | | |
| Employee signature _____ | | | | | | Date signed ____ / ____ / ____ | | | | | | | |
| Please note: 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. | | | | | | | | | | | | | |

PRIVACY POLICY

We may collect, use, or disclose personal information about you, including health information, your address, telephone number or Social Security number. We may receive this information from, or release it to, healthcare providers, insurance companies, or other sources to conduct our routine business operations such as: underwriting and determining your eligibility for benefits and paying claims; coordinating benefits with other healthcare plans; conducting care management, case management, or quality reviews. This information may also be collected, used or released as required or permitted by law.

To safeguard your privacy and ensure your information remains confidential, we train all employees on our written confidentiality policy and procedures. If a disclosure of your personal information is not related to a routine business function, we will remove anything that could be used to easily identify you, unless we have your prior authorization to release such information.

You have the right to request inspection and/or amendment of your records retained by us.

To view or print copies of our detailed Privacy Notice and other forms, please visit our website at leofftrust.net. To have forms mailed to you, please call the number below.

SPECIAL ENROLLMENT RIGHTS

If you are declining enrollment for yourself or dependents (including your spouse) because of other healthcare coverage, you may in the future enroll yourself or your dependents in this plan prior to the next open enrollment period. To do this, you must have involuntarily lost your other coverage and we must receive your enrollment application within 30 days after your other coverage ended (60 days if the prior coverage was through Medicaid or CHIP). Additionally, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and dependents, provided we receive your completed enrollment application within 30 days after the marriage, birth, adoption, or placement for adoption, unless a different time limit has been specified in your benefit booklet.

LATE ENROLLEES

A "Late Enrollee" is an individual or family dependent who did not enroll when first eligible for coverage under this plan and does not qualify as a Special Enrollee. If you or your dependents are Late Enrollees, you or your dependents may enroll during the next occurring Annual Group Enrollment Period.

CREDITABLE COVERAGE

"Creditable Coverage" means prior or ongoing healthcare coverage including any group healthcare coverage (including the Federal Employees Health Benefits Plan and the Peace Corps), individual healthcare coverage (including student health plans), Medicare, Medicaid, CHAMPUS, Indian Health Service or tribal organization coverage, state high-risk pool coverage, state Children's Health Insurance Programs (CHIP), a public health plan established or maintained by a State, the U.S. government, a foreign country, or any political subdivision of a State, the U.S. government, or a foreign country that provides health coverage to individuals who are enrolled in the plan.

If you have any questions about the information included in this notice, please call us at 509-484-2388.