



Employer Name		Effective Date / /	Hire/Event Date / /	Reason For Enrollment <input type="checkbox"/> Hire/Rehire <input type="checkbox"/> Loss of Coverage <input type="checkbox"/> Birth/Adoption <input type="checkbox"/> Open Enrollment <input type="checkbox"/> COBRA/Extension <input type="checkbox"/> Address/Name Change <input type="checkbox"/> Add Dependants <input type="checkbox"/> Delete Dependants <input type="checkbox"/> Other _____ <input type="checkbox"/> Termination    Date of Termination _____	
Group #:		Hours per Week _____			
<b>EMPLOYEE INFORMATION: PLEASE PRINT CLEARLY</b>					
First Name, Middle Initial, Last Name			Employee's Birth Date / /	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Social Security #
Mailing Address	City	State	Zip	Phone	Annual Salary    Occupation
<b>PLAN SELECTIONS</b>					
<b>Medical</b> <i>*If no coverage selected, please attach waiver form. If Medical coverage is waived, participant will not be enrolled in the groups' \$15,000 basic life benefit.</i>	Asuris Northwest Health: <input type="checkbox"/> Progressive 650 100/80/80/50/25 <input type="checkbox"/> PPO Advance \$500 \$25 <input type="checkbox"/> PPO Advance \$1000 \$25 <input type="checkbox"/> HSA 80/80/60 \$1500		Group Health Options, Inc.: <input type="checkbox"/> Alliant Plus Welcome, \$200 <input type="checkbox"/> Alliant Plus Welcome, \$500 <input type="checkbox"/> Alliant Plus Welcome, \$1000 <input type="checkbox"/> Alliant \$350 Deductible <input type="checkbox"/> Alliant Plus \$20 Copay		
<b>Dental</b>	Washington Dental Service ( 5 + Employees ) <input type="checkbox"/> Plan A <input type="checkbox"/> Plan F <input type="checkbox"/> Plan G <input type="checkbox"/> Plan H <input type="checkbox"/> Orthodontia Rider <input type="checkbox"/> Family Orthodontia Rider		Dental Health Services ( 1 + Employee ) <input type="checkbox"/> SmartSmile <input type="checkbox"/> Super SmartSmile		
<b>*LifeWise Assurance Company Basic Life and AD&amp;D</b>	<input type="checkbox"/> Plan A - \$15,000 <input type="checkbox"/> Plan B - \$50,000 <input type="checkbox"/> Plan C - 1 x Annual Salary (\$100,000 maximum) <input type="checkbox"/> Plan D - 2 x Annual Salary (\$200,000 maximum) (Amounts above the Guarantee Issue require a completed Evidence of Insurability form) GI Groups size = 5 - 9 = \$50,000    10 - 49 = \$75,000    50 - 99 = \$100,000				
<b>LifeWise Assurance Company Supplemental Life and AD&amp;D</b>	Increments of \$10,000 to a maximum of \$200,000 In no event shall the combined Basic and Supplemental benefits exceed \$250,000. (Available if employer elects coverage) <input type="checkbox"/> Amount _____ Employer Group Size: 5- 49 = EE GI \$25,000 Sp GI \$10,000 Employer Group Size 50-99 = EE GI \$50,000 Spouse GI \$25,000				
<b>LifeWise Assurance Company Long Term Disability</b>	<input type="checkbox"/> Plan A 60%- \$3K, 90EP <input type="checkbox"/> Plan B 60%- \$3K, 180EP <input type="checkbox"/> Plan C 60%- \$6K, 90EP <input type="checkbox"/> Plan D 60%- \$6K, 180 EP (If you waive coverage and elect to enroll at a later date you will need to submit satisfactory Evidence of Insurability before you can be insured under the LTD plan.)				
<b>Vision</b>	<input type="checkbox"/> Vision Service Plan Signature Plan B <input type="checkbox"/> Vision Service Plan Signature Choice		<b>Employee Assistance Plan</b>	<input type="checkbox"/> Wellspring Family Services (1 -3 Visit model)	
<b>Group Legal Plan</b>	<input type="checkbox"/> 21 <sup>st</sup> Century Legal Plan (Complete separate 21 <sup>st</sup> Century Legal Plan form)		<b>Voluntary Personal Accident</b>	<input type="checkbox"/> Provided by AIG (Complete separate AIG enrollment form)	
<b>Coordination of Benefits</b>					
Other Insurance Carrier:			Policy ID #:	Effective Date:	
Policy Holder's Name:			Phone #:	Date of Birth:	Social Security #:
If you have Medicare What is the Begin date for:	Part A:	Part B:	Medicare HIC # with Alpha Suffix:		

ENROLLEE INFORMATION							
*Add or Delete (Circle One)	*Name of Dependent (If dependent has different mailing address, please attach) First Last	*Birth Date (Over Age 25 requires certificate)	*Coverage (Circle all that apply)	*Gender (Circle One)	Social Security #	Prior Coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No (if 'Yes' indicate Prior Coverage Below)	
						Primary Care Physician (PCP) Required for Selections Plans	Primary Care Physician (PCP) ID Number
Add/Delete	Self	/ /	Med Dent Vis	M F			
Add/Delete	Spouse/DP	/ /	Med Dent Vis	M F			
Add/Delete	Child	/ /	Med Dent Vis	M F			
Add/Delete	Child	/ /	Med Dent Vis	M F			
Add/Delete	Child	/ /	Med Dent Vis	M F			

**For individuals who are eligible for enrollment in an employer group health plan:** If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or employer group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if, in the case of employer group health plan coverage, the employer stops contributing toward you or your dependents' other coverage.) However, you must request enrollment within 30 Days after you or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). In addition, if you gain a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 60 days after the marriage, birth, adoption, or placement for adoption.

**Prior Medical Coverage (Preexisting condition waiting period is 3 months. Period may be credited with prior, continuous coverage).**

Prior Medical Carrier and Policy #:	List all participants enrolled in prior medical plan:	Effective Date:
		Termination Date:

EMPLOYEE BENEFICIARY:	Primary Beneficiary Name and Relationship* for Basic Life/AD&D and Supplemental Life and/or AD&D	Primary Beneficiary Address
EMPLOYEE BENEFICIARY:	Contingent Beneficiary Name and Relationship** for Basic Life/AD&D and Supplemental Life and/or AD&D	Contingent Beneficiary Address

\* If more than one primary beneficiary is named, the primary beneficiaries shall share equally unless otherwise indicated above. \*\* Contingent Beneficiary(ies) will only receive proceeds if all Primary Beneficiaries have predeceased the Insured. If you are naming more than one Contingent Beneficiary at 100% each, please indicate them in order of precedence. In community property states, 50% of the payable benefit will be paid to the spouse unless the spouse signs a statement waiving the rights to the proceeds.

SIGNATURE			
I hereby apply for enrollment or change of enrollment as indicated on this application. I understand that Business Health Trust and the Insurers may collect, use and disclose protected health information about each individual enrolled under this application in order to carry out their routine business functions, including but not limited to, determining eligibility for benefits, paying claims, coordinating benefits with other insurance carriers or payer, underwriting and conducting case management care management and quality reviews. Business Health Trust and the Insurers may also disclose protected health information to state and federal agencies, or other third parties, as required by law. The information will otherwise be held confidential.			
I acknowledge and understand my health plan may request or disclose health information about me or my dependents (persons who are eligible for benefits coverage and are listed on the enrollment form) 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: a physician, dentist, pharmacist or other physical or behavioral health care practitioner; a clinic, hospital, long term care or other medical facility; any other institution providing care treatment, consultation, pharmaceuticals or supplies; or 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 Notice of Privacy Practices. A copy is available from the Asuris Northwest Health Web site at www.asuris.com or by phone at 1-888-344-5587.			
Employee Signature	Date	Employer Signature	Date