



## Section 5 > Dependents

Relationship code: **SP** = spouse; **DP** = domestic partner; **RDP** = registered domestic partner (*DP and RDP only if applicable to your plan*)  
Please use additional form if needed.

Add	Term	Med	Den	Dependent First Name*	Dependent Last Name*	Social Security No.*	Date of Birth* (mm/dd/yyyy)	Gender*	Relationship*	Primary Language (if different from employee)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> SP <input type="checkbox"/> DP <input type="checkbox"/> RDP	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					<input type="checkbox"/> M <input type="checkbox"/> F	Child <sup>1</sup>	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					<input type="checkbox"/> M <input type="checkbox"/> F	Child <sup>1</sup>	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Child <sup>1</sup> <input type="checkbox"/> Ward	

## Section 6 > Other Insurance (coordination of benefits)

Will employee or any dependents have other insurance?  Yes  No

If your Group's size is less than 20 employees, Medicare will be assumed to be the primary payer and we will coordinate benefits as the secondary payer even if you have not elected coverage under Medicare. When your Group's size is 20 employees or more, Medicare will be considered the secondary payer.

## Section 7 > Waiver of Coverage Information

Please include the names of all eligible members who will NOT be enrolling. *Please use additional form if needed.*

Person Waiving	Reason for Waiver	Health Plan Name	Policy No.	Employer Group Name
	<input type="checkbox"/> Individual <input type="checkbox"/> Employer Group <input type="checkbox"/> Medicare <input type="checkbox"/> Other _____			
	<input type="checkbox"/> Individual <input type="checkbox"/> Employer Group <input type="checkbox"/> Medicare <input type="checkbox"/> Other _____			

**Notice:** If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may, in the future, be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 31 days after your other coverage ends.\* In addition, 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 your dependents, provided that you request enrollment within 31 days after marriage, birth, adoption or placement for adoption.

\*If prior coverage was under Medicaid or a children's health insurance program (CHIP) you must request enrollment within 60 days after the coverage ends.

## Section 8 > Authorization (please read and sign below)

I acknowledge and understand my health plan may request or disclose health information about me or my dependents (people 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.<sup>2</sup>

Health information requested or disclosed may be related to treatment or services performed by:

- A physician, dentist, pharmacist or other physical or behavioral healthcare 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 HIV/AIDS, psychotherapy notes, alcohol/drug and genetic testing. A separate authorization will be used for information related to these health conditions. It is a crime to knowingly provide false, incomplete, or misleading information to a health carrier for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of health coverage.

**I certify that the information provided on this form is true and correct to the best of my knowledge. I acknowledge that my enrollment form will be delayed if all fields with an asterisk are not filled out entirely.**

Employee Signature* X	Signature Date*
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\*Enrollment will be delayed if fields with an asterisk are not filled out.

<sup>1</sup> Please list only eligible dependent children. See Section 5 for dependent children qualifications.

<sup>2</sup> 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 by calling the Privacy Office at 503-952-5033.