WASHINGTON FARM BUREAU
Healthcare

Selected insurance products underwritten by;

Request for Benefit Coverage

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Employer Name

☐ New Employee
☐ Delete Dependent
☐ Terminate Coverage
☐ Name or Address Change
☐ Beneficiary Change

☐ Add Dependent
Reason: ☐ Loss of Other Group Coverage
☐ Marriage:
☐ Adoption:
☐ Birth

☐ Other______________________
☐ 6 Month Continuation of Coverage
Date of Marriage: _______________
Date of Adoption: _______________
Date of Birth: __________________

Employer Group Number: 1 0 ____ ____ ____ ____
Enrollee Date of Hire: _____ / ______ /_______
Enrollee Requested Effective Date: _____ / 01 / 2009

Enrollee Information (Complete All Sections - Please Print)							
Last Name First Name M.I.	Sex	Date of Birth	Social Security Number	Home Phone	Work Phone	E-mail	
Address		Apt. #	City		State	Zip	
Are you covered by Workers' Compensation? ☐ Yes ☐ No ☐ Exempt		Current Job Title:			Marital Status: ☐ Single ☐ Married ☐ Divorced		
Enrollee Prior Medical Coverage? ☐ Yes ☐ No	Prior Carrier		Start Date of Prior Coverage		End Date of Prior Coverage		

Dependent Information (Please fill out all that applies) Dependents Covered Until Age 25							Dependent Previous Coverage Information - HIPAA	
Relationship to Employee	Last Name	First Name M.I.	Sex	Date of Birth	Social Security Number	Previous Carrier	Start Date of Prior Coverage	End Date of Prior Coverage

Life Insurance Beneficiary	Name	Address	Relationship

Medical Insurance Benefits are underwritten by: Regence BlueShield; 1800 Ninth Avenue; PO BOX 21267; Seattle, WA 98111-3267
Life Insurance Benefits are underwritten by: Regence Life and Health Insurance; PO Box 1271, MS E3A; Portland, OR 97207-1271
Vision Insurance Benefits are underwritten by: Vision Service Plan; 600 University Street, Suite 2004; Seattle, WA 98101
Dental Insurance Benefits are underwritten by: Washington Dental Service; 9706 Fourth Avenue NE; Seattle, WA 98115

HIPAA Privacy, Disclosure and Release of Information

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. *For more information about such uses and disclosers, including uses and disclosures required by law, please refer to the Notice of Privacy Practice. A copy is available from the Regence BlueShield website at: www.wa.regence.com or by phone at 1-800-458-3523 or 1-206-464-3663.

Fraud Warning Statement

I have provided these answers as part of the application procedure required by the issuer to enroll in coverage and I certify that all information completed on this form is true, correct, and complete. I understand that the issuer will rely on each answer in making coverage and rating determinations. For the protection of all of our members, fraud or misrepresentation of material fact by me for the purposes of defrauding the issuer may result in the issuer taking any action allowed by law or contract, including termination or rescission of coverage, denial of benefits, and/or pursuit of criminal charges and penalties.

Original Applicant Signature:______________________________ **Date:**______________________________