



## Request for Benefit Coverage

\_\_\_\_\_  
Employer Name

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> New Employee           | <input type="checkbox"/> Add Dependent                        | <input type="checkbox"/> Other _____                      |
| <input type="checkbox"/> Delete Dependent       | Reason: <input type="checkbox"/> Loss of Other Group Coverage | <input type="checkbox"/> 6 Month Continuation of Coverage |
| <input type="checkbox"/> Terminate Coverage     | <input type="checkbox"/> Marriage: _____                      | Date of Marriage: _____                                   |
| <input type="checkbox"/> Name or Address Change | <input type="checkbox"/> Adoption: _____                      | Date of Adoption: _____                                   |
| <input type="checkbox"/> Beneficiary Change     | <input type="checkbox"/> Birth                                | Date of Birth: _____                                      |

Employer Group Number: 1 0 \_\_\_\_\_

Enrollee Date of Hire: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Hours per Week: \_\_\_\_

Enrollee Requested Effective Date: \_\_\_\_ / 01 / 2010

### 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? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Exempt			Current Job Title:		Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced	
Enrollee Prior Medical Coverage? <input type="checkbox"/> Yes <input type="checkbox"/> 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
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Medical Insurance Benefits are underwritten by Asuris Northwest Health | 528 East Spokane Falls Boulevard, Suite 301 | Spokane, WA 99202  
 Life Insurance Benefits are underwritten by Regence Life and Health Insurance Company | 100 SW Market Street | P.O. Box 1271 | Portland, OR 97207-1271  
 Dental Insurance Benefits are underwritten by Washington Dental Service | 9706 4th Avenue NE | Seattle, WA 98115  
 Vision Insurance Benefits are underwritten by Vision Service Plan | 600 University Street, Suite 2004 | Seattle, WA 98101

### 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, 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 disclosures, including uses and disclosures required by law, please refer to the Notice of Privacy Practice. A copy is available from the Asuris Northwest Health website at: [www.asuris.com](http://www.asuris.com).

### 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:** \_\_\_\_\_