Selected insurance products underwritten by;

Request for Benefit Coverage

____
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: _____ / ______ / _______ 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? ☐ 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
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, 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.

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:**_______________________________

Employer Name
Applicant Date of Hire: _____ / _____ / ______

Waiver of Coverage

Waiver Information (Complete All Sections - Please Print)

Last Name	First Name	M.I.	Sex	Date of Birth	Social Security Number

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Enrollee Prior Coverage? ☐ Yes ☐ No If yes, how many?

Family Members (To be waived)

Relationship to Employee	Last Name	First Name M.I.	Sex	Date of Birth	Currently Covered Yes / No	If yes, Name of Carrier

Confirmation of Decision to Decline Coverage

This is to confirm that I decline to participate in the Washington Farm Bureau heath care program(s) offered through my employer's group health plan as follows (Please mark all that apply):

☐ I do not wish to enroll **myself**. I have other health care coverage**.**

☐ I do not wish to enroll **myself**. I do not have other health care coverage.

☐ I do not wish to enroll my ____ **spouse** ____ **child(ren)**. They have other health care coverage.

☐ I do not wish to enroll my ____ **spouse** ____ **child(ren)**. They do not have other health care coverage.

I understand that by **declining** enrollment for myself or dependents (including my spouse) because of other health care coverage, I may in the future enroll my dependents or myself in this plan only under the conditions stated herein. To be eligible at another time, I must have **involuntarily** lost my other coverage and we must receive your enrollment application within 30 days after your other coverage ended.

Additionally, if I have a new dependent as a result of marriage, birth, adoption, or placement for adoption, I may be able to enroll myself and dependents, provided we receive your completed enrollment application within 60 days after the marriage, birth, adoption, or placement for adoption. I understand that these are the only conditions under which I may enroll after my current initial eligibility.

Applicant / HIPAA Acknowledgement. I am an active full-time employee regularly working at least 30 hours per week. All information given by me on this form is true and complete. My signature below certifies the carrier/coverage data provided above is complete and accurate to the best of my knowledge, and can be documented upon request with Group Health Plan Coverage Certificates from my, and my dependents prior plan(s). I acknowledge the authorization for the Washington Farm Bureau to obtain information from third parties regarding any matters that may bear on this application.

I have provided these answers as part of the application procedure required by the issuer to waive 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 protection of all 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: