

Combined insurance enrollment form

Complete entire form to enroll or make changes.

Employer – Please note that failure to fully complete this form may result in this form being returned to you and will delay the processing of the form. Please proof this form carefully.

Employer

Employer to complete this section and send completed form to AWC at benefitinfo@awcnet.org or fax to 360.753.0149 or mail to 1076 Franklin Street SE, Olympia, WA 98501-1346

Employer name

Date of hire

Effective date of change

Employee's occupation

Class/bargaining unit

Salary Annual \$ _____

Monthly \$ _____

Weekly \$ _____

Hourly \$ _____

Enrollment

Changes

Has there been a change that affects your insurance? Check **all the changes** that apply to you **and complete the entire form.**

- New hire
- New group
- Open enrollment
January 1

- Name Address Marriage Domestic Partnership Divorce Legal separation Beneficiary

Other (be specific) _____

- Add dependent (check reason) Marriage Domestic Partnership Newborn
- Other reason (be specific) _____

Drop dependent Comments _____

Employee

Please print legibly in blue or black ink.

SSN

Employee name (last, first, initial)

Date of birth

Gender

Single

Married

Divorced Date divorced: _____

Partnership termination

Partnership termination date: _____

Mailing address

Phone (with area code)

City

State

Zip

Email address

Type of coverage requested (check all that apply):

- Medical
- Dental
- Vision
- Life
- Long-term disability
- EAP

Carriers and specific plans are listed on the back of this form.

Are you adding this coverage due to a recent loss of coverage? Yes No If yes, complete below.

Name of other insurance company

Type of insurance (medical, dental, etc.)

Group#

Policy #

Effective date

Termination date

Insured's SSN

Name (last, first, initial)

Spouse/ Domestic Partner

Please list spouse/domestic partner who should be covered on your insurance. Leaving them off will terminate coverage. Proof of dependency will be requested, including, but not limited to, marriage certificate, affidavit of marriage/domestic partnership, joint ownership documents.

SSN	Spouse/DP name (last, first, initial)	Date of birth	Gender
Date married:	Date met DP criteria:		
Type of insurance requested:	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Life		
Are you adding this coverage due to a recent loss of coverage?		<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, complete below.
Name of insurance company	Type of insurance (medical, dental, etc.)	Group#	Policy #
Effective date	Termination date	Phone #	

Dependents

Please list all dependents that should be covered on your insurance. Leaving them off the form will terminate coverage. Proof of dependency will be requested, but not limited to, birth certificate, adoption papers. **Medical, dental & vision:** A dependent is a child, stepchild or adopted child; less than age 26 or prior to age 26 was incapable of self-support due to developmental disabilities or physical handicap (proof of incapacity required). **Life:** A dependent is a child, stepchild or adopted child from birth but less than age 26.

**Please check all appropriate boxes and fill in the appropriate blanks.
For additional dependents, please fill out additional forms and alter "Dependent # ____."**

Dependent #1

Name (last, first, middle initial)		
SSN _____		
Gender	Date of birth	Relationship to insured

Type of insurance requested:

Medical Dental Vision Life

Are you adding this coverage due to a recent loss of coverage? Yes No

If yes, name of other insurance company & type (medical, dental, etc.)

Name of insured (last, first, initial) SSN of insured

Group/policy # Effective date Termination date

Does he/she live with you? Yes No

Mailing address Home phone

City State Zip

Dependent #2

Name (last, first, middle initial)		
SSN _____		
Gender	Date of birth	Relationship to insured

Type of insurance requested:

Medical Dental Vision Life

Are you adding this coverage due to a recent loss of coverage? Yes No

If yes, name of other insurance company & type (medical, dental, etc.)

Name of insured (last, first, initial) SSN of insured

Group/policy # Effective date Termination date

Does he/she live with you? Yes No

Mailing address Home phone

City State Zip

Dependents

Please list all dependents that should be covered on your insurance. Leaving them off the form will terminate coverage. Proof of dependency will be requested, but not limited to, birth certificate, adoption papers. **Medical, dental & vision:** A dependent is a child, stepchild or adopted child; less than age 26 or prior to age 26 was incapable of self-support due to developmental disabilities or physical handicap (proof of incapacity required). **Life:** A dependent is a child, stepchild or adopted child from birth but less than age 26.

**Please check all appropriate boxes and fill in the appropriate blanks.
For additional dependents, please fill out additional forms and alter "Dependent # _____".**

Dependent #3			Dependent #4		
Name (last, first, middle initial)			Name (last, first, middle initial)		
SSN			SSN		
Gender	Date of birth	Relationship to insured	Gender	Date of birth	Relationship to insured
Type of insurance requested: <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Life			Type of insurance requested: <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Life		
Are you adding this coverage due to a recent loss of coverage? If yes, name of other insurance company & type (medical, dental, etc.)			Are you adding this coverage due to a recent loss of coverage? If yes, name of other insurance company & type (medical, dental, etc.)		
Name of insured (last, first, initial)		SSN of insured	Name of insured (last, first, initial)		SSN of insured
Group/policy #	Effective date	Termination date	Group/policy #	Effective date	Termination date
Does he/she live with you? <input type="checkbox"/> Yes <input type="checkbox"/> No			Does he/she live with you? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Mailing address		Home phone	Mailing address		Home phone
City		State	City		State
		Zip			Zip

Employee plan enrollment (Please check all that apply.)

Medical



1111 Lake Washington Blvd N.
Suite 900
Renton, WA 98057
 Regence BlueShield
 AWC HealthFirst® 250
 AWC HealthFirst® 500
 High Deductible Health Plan



2715 Naches Ave. SW
Renton, WA 98057
 Kaiser Foundation Health Plan of Washington
 \$200 Deductible Plan
 \$500 Deductible Plan
 High Deductible Health Plan

Decline medical coverage



528 E Spokane Falls Blvd,
Suite 301
Spokane, WA 99202
 Asuris Northwest Health
 AWC HealthFirst® 250
 AWC HealthFirst® 500
 High Deductible Health Plan



2715 Naches Ave. SW
Renton, WA 98057
 Kaiser Foundation Health Plan of Washington Options, Inc.
 Access PPO

Vision



3333 Quality Drive
Rancho Cordova, CA 95670
Vision Service Plan (071038Z2)

No copay
 \$10 copay
 \$25 copay
 \$10/\$15 copay plan
 Second pair rider

Employee Assistance Program



NBC Tower
455 N. Cityfront Plaza Drive
Chicago, IL 60611-5322
ComPsych
 1-6 sessions - Included when enrolled on any AWC Trust plan
 1-8 Buy-up
 1-10 Buy-up

Dental



Delta Dental of Washington
400 Fairview Ave N
Seattle, WA 98109-5371
Delta Dental of Washington Basic (0177)

Plan A
 Plan B
 Plan C
 Plan D
 Plan E
 Plan F
 Plan G
 Plan J

Orthodontia

Option I
 Option II
 Option III
 Option IV
 Option V

Life



1100 SW 6th Ave
Portland, OR 97204
Standard Insurance Company

Basic life w/AD&D
\$ _____

Dependent life
 Plan option 1
 Plan option 2
 Plan option 3
 Plan option 4

Employee additional life
\$ _____

Note: EOI form required if over \$80,000.

Spouse additional life
\$ _____

Note: EOI form required if over \$20,000.



Willamette Dental Group

6950 NE Campus Way
Hillsboro, OR 97124

Willamette Dental of Washington, Inc.

\$10 copay
 \$15 copay

Long-term disability



1100 SW 6th Ave
Portland, OR 97204
Standard Insurance Company

90-day: 60% benefit
 90-day: 67% benefit
 180-day: 60% benefit
 180-day: 67% benefit