

CENTRAL WASHINGTON SCHOOL EMPLOYEES BENEFIT TRUST

underwritten by: **Regence BlueShield**, 1800 Ninth Ave, Seattle, WA 98101

Employee Name				Last		First		Middle Initial		Social Security #		For Office Use Only			
(Street or P.O. Box, City, State, Zip Code)												Effective Date			
Mailing Address						Occupation						Date of Hire			
Mo.		Day		Year		Gender		Marital Status		Single <input type="checkbox"/>		Married <input type="checkbox"/>			
Date of Birth		M		F		Home Phone #		Work Phone #		Bldg.					
Select One of the Following: TRADITIONAL <input type="checkbox"/> SELECT <input type="checkbox"/> ECONOMY <input type="checkbox"/>										I am applying for coverage for:				<input type="checkbox"/> Myself Only <input type="checkbox"/> Self & Spouse <input type="checkbox"/> Self & Family <input type="checkbox"/> Self & Children	
Instructions: List all dependents to be covered; added or dropped. All fields must be completed for each beneficiary change or enrollment change. Information on this form supercedes any forms previously completed.						Change in Enrollment: Date of change _____ <input type="checkbox"/> Name <input type="checkbox"/> Death <input type="checkbox"/> Adoption (placement date) _____ <input type="checkbox"/> Beneficiary <input type="checkbox"/> Dependent Change <input type="checkbox"/> Divorce (date) _____ <input type="checkbox"/> DP (Domestic Partner and/or dependent of DP); must attach DP affidavit <input type="checkbox"/> Marriage (date) _____ <input type="checkbox"/> Other <input type="checkbox"/> Birth									
Please fill out for new employee application and/or addition of dependents. IMPORTANT - Filling out Sections 1, 2 and 3 below will assist in processing your claims.															
1. Do you or any dependent(s) applying for coverage have coverage with any other health care plan now or within the last 3 months? This includes coverage through another insurance company, another Blue Shield plan, Medicare, a self-insured plan or a group retirement plan. <input type="checkbox"/> NO If No, please skip the rest of this section, section 2 and section 3, and complete the remainder of the application form in full. <input type="checkbox"/> YES If Yes, please complete the rest of this section and the remainder of the application form in full.															
Insurance Company Name and Phone Number				Insurance Company Address (city and state)				Employer		Identification/Policy #		Name(s) & DOB of person(s) covered by other insurance:			
Policyholder's Name		Policyholder's Birthdate / /		Date Coverage Began / /		Is coverage still in effect <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, will coverage still be in effect when this policy begins? <input type="checkbox"/> Yes <input type="checkbox"/> No		If no, date coverage ended or will end?					
Type of Coverage		<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Medicare													
If you have other types of coverage and the carrier(s) is/are different than specified above, please indicate to the right. ➔				Insurance Company Name and Address (city & state)				Type of Coverage		<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Medicare					
2. If you have Medicare, what was the begin date for Part A: _____ B: _____ D: _____ Medicare HIC # with Alpha Prefix: _____ Reason: <input type="checkbox"/> Disability <input type="checkbox"/> Over age 65 <input type="checkbox"/> End Stage Renal Disease															
Name Of Child(ren)				Father		Mother		Joint		Other		Date Awarded _____			
Is the parent without custody required by court decree to provide coverage for the children? Yes No												If "Yes" list other coverage provided _____			
If you and your spouse are divorced or legally separated, please indicate below who has Legal custody of your child(ren): _____															
Add	Drop	No Change	Relationship To Insured	Name				Gender M / F	Date of Birth Mo. Day Year			Social Security Number	Is your child eligible for other employer sponsored coverage through his/her employer or spouse?		
			Employee										<input type="checkbox"/> Yes <input type="checkbox"/> No		
			Spouse										<input type="checkbox"/> Yes <input type="checkbox"/> No		
			Child										<input type="checkbox"/> Yes <input type="checkbox"/> No		
			Child										<input type="checkbox"/> Yes <input type="checkbox"/> No		
			Child										<input type="checkbox"/> Yes <input type="checkbox"/> No		
Underwritten by: Regence Life and Health, P.O. Box 1271, Portland, Oregon 97207-1271															
Primary Life Insurance Beneficiary _____						Relationship to Insured _____									
Contingent Life Insurance Beneficiary _____						Relationship to Insured _____									
I hereby apply for enrollment, change, or cancellation of coverage as indicated above. I understand any coverage will be under the master contract between Regence BlueShield and my employer and I agree to the terms and conditions of the certificate issued pursuant to it.															
I hereby verify that I have reviewed all the information provided on this application (regardless of whether I completed it or someone else assisted me with completion) and certify that it is accurate and complete. I agree to promptly inform Regence BlueShield in writing if anything happens before my coverage takes effect that makes any answer on this application inaccurate or incomplete.															
Applicant's Signature _____												Date _____			

I agree to abide by the Employer's enrollment provisions and certify that all those who I seek to enroll, including myself, meet the eligibility criteria as agreed to by the Group in the master contract. I understand that coverage cannot start until after I have served an eligibility waiting period agreed to by the employer as recorded on Regence BlueShield's records.

An eligible individual not listed on this application will be considered as waiving coverage. I acknowledge that I have had the opportunity to enroll, but do not wish to make application for any eligible individual not listed. In waiving coverage, I am aware that waiving individuals (including me, if I am waiving) may enroll later only at my group's anniversary, unless qualified for a Special Enrollment Period.

If I have waived enrollment for myself or any of my dependents (including my spouse/domestic partner) because of other health insurance or group health plan coverage, I may in the future be able to enroll the waived individuals in this plan, provided I request enrollment within 30 days after the other coverage of the individual(s) ends due to loss of eligibility or an employer's ceasing to contribute toward that other coverage. In addition, if I have a new dependent as a result of marriage domestic partnership, birth, adoption, or placement for adoption, I may be able to enroll myself and my dependents, provided that I request enrollment within 30 days after the marriage/domestic partnership, or within 60 days after the birth, adoption, or placement if payment of additional premium is required to provide coverage for the child. To obtain more information about these rules, please call 1(800) 505-6801.

Except by express amendment signed by an officer of Regence BlueShield, no person, including, but not limited to any independent producer, agent, or employee of Regence BlueShield or of my employer, may change the terms of the master contract, any of its amendments, or this application and no person may waive the requirement that I answer all questions on this application completely and accurately. I understand that this application will become part of the contract between Regence BlueShield and my employer.

I authorize my employer to act as my agent in all matters of administration of the group coverage, and acknowledge that my employer is in no way acting as agent for Regence BlueShield. I agree to pay the appropriate premium rates for myself and my enrolling dependents in advance, and authorize payroll deduction of premiums as required.

I authorize any source to release to Regence BlueShield, any medical, health, employment, and/or insurance information requested for any enrolled member. I acknowledge and understand that Regence BlueShield 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) 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. 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 acknowledgment does not apply to obtaining information regarding psychotherapy notes. A separate authorization will be used for psychotherapy notes.

I understand that a waiting period for coverage of preexisting conditions may apply. **The preexisting waiting period may not apply to any members under the age of 19.** Contact your Group Administrator for more information. A preexisting condition waiting period may be reduced by any prior creditable health coverage I and/or my dependent(s) may have had, as long as there was not a significant lapse in coverage. I have the right to provide evidence of prior coverage. I can contact Regence BlueShield for assistance in obtaining proper evidence of prior coverage.

I have provided these answers as part of the application procedure required by Regence blueShield to enroll in coverage and I certify that all information completed on this form is true, correct and complete. I understand that Regence BlueShield will rely on each answer in making coverage and rating determinations. It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purposes of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.