Mail to:
PO Box 3048, MS 737
Spokane, WA 99220-3048
premera.com

Small Group Member Enrollment and Change Application

General information (group complete) **All fields are required**			
Group ID	Group name	Employee class/subgroup (as applicable)	Employee hire date / /
Enrollment reason	Enrollment reason date ☐ Same as hire date ☐ Other date / /	If COBRA, indicate number of months: ☐ 18 months ☐ 29 months ☐ 36 months	Plan start date / /

Employee information (employee complete) **All fields are required** | Please indicate names as you would like them to appear on the ID card. (Limit of 26 characters including spaces)			
Employee name (Last)	(First)	Phone number ( )	Email address
Mailing address	City	State	ZIP code

Enrollment Information (employee complete) **All fields are required**	
Medical plan choice	Dental plan choice (as applicable)

Relationship to employee	Last name	First name	Social Security number	Date of birth	Gender	Add	Drop	Benefit selection
Self				/ /		☐	☐	☐ **Medical** ☐ **Dental**

SSN is required for any member over the age of 44.

Primary language	**Ethnicity – check all that apply** (optional)		
☐ English ☐ Spanish ☐ Other_________	☐ American Indian/Alaskan Native ☐ Asian ☐ Black African American	☐ Native Hawaiian/Pacific Islander ☐ Hispanic/Latino	☐ Not Hispanic or Latino ☐ White

Relationship to employee	Last name	First name	Social Security number	Date of birth	Gender	Add	Drop	Benefit selection
				/ /		☐	☐	☐ **Medical** ☐ **Dental**

Primary language	**Ethnicity – check all that apply** optional)		
☐ English ☐ Spanish ☐ Other_________	☐ American Indian/Alaskan Native ☐ Asian ☐ Black African American	☐ Native Hawaiian/Pacific Islander ☐ Hispanic/Latino	☐ Not Hispanic or Latino ☐ White

Relationship to employee	Last name	First name	Social Security number	Date of birth	Gender	Add	Drop	Benefit selection
				/ /		☐	☐	☐ **Medical** ☐ **Dental**

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Relationship to employee	Last name	First name	Social Security number	Date of birth	Gender	Add	Drop	Benefit selection
				/ /		☐	☐	☐ **Medical** ☐ **Dental**

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Relationship to Employee	Last name	First name	Social Security number	Date of birth	Gender	Add	Drop	Benefit selection
				/ /		☐	☐	☐ **Medical** ☐ **Dental**

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Relationship to employee	Last name	First Name	Social Security number	Date of birth	Gender	Add	Drop	Benefit selection
				/ /		☐	☐	☐ **Medical** ☐ **Dental**

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Employee signature

In applying for enrollment as indicated on this application, I declare that all of the information on this form is true and complete to the best of my knowledge. I also declare that each person I am requesting enrollment for is eligible for coverage. I have also read and understand the provisions as stated in the Notices section of this document. The changes on this form supersede all previous forms submitted.

Employee signature____ Date signed___ / ____ / ______

Please note: *It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.*

Notices

Premera privacy policy

We may collect, use, or disclose personal information about you, including health information, your address, telephone number, or Social Security number. We may receive this information from, or release it to, healthcare providers, insurance companies, or other sources to conduct our routine business operations such as: underwriting and determining your eligibility for benefits and paying claims; coordinating benefits with other healthcare plans; or conducting care management, case management, or quality reviews. This information may also be collected, used, or released as required or permitted by law.

To safeguard your privacy and ensure your information remains confidential, we train all employees on our written confidentiality policy and procedures. If a disclosure of your personal information is not related to a routine business function, we will remove anything that could be used to easily identify you, unless we have your prior authorization to release such information.

You have the right to request inspection and/or amendment of your records retained by us.

To view or print copies of our detailed Privacy Notice and other forms, please visit our website at premera.com. To have forms mailed to you, please call the number below.

Special enrollment rights

If you are declining enrollment for yourself or dependents because of other healthcare coverage, in the future you may enroll yourself or your dependents in this plan prior to the next open enrollment period. To do this, you must have involuntarily lost your other coverage and we must receive your enrollment application within 60 days after your other coverage ended. Additionally, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and dependents, provided we receive your completed enrollment application within 60 days after the event, unless a different time limit has been specified in your benefit booklet.

Late enrollees and state continuation of coverage

A late enrollee is an individual or family dependent who did not enroll when first eligible for coverage under this plan. A late enrollee doesn't qualify as a special enrollee. If you or your dependents are late enrollees, you may enroll during the next annual group enrollment period.

If you are enrolling under state continuation of coverage (COC), the eligible period of coverage cannot exceed 3 months

Required Social Security number and contact email address

Under the Affordable Care Act (ACA), all health plans must provide an IRS Form 1095-B to fully insured members starting in 2016. You'll need Form 1095-B to help you file your taxes, much like your W-2.

If you have any questions about the information included in this notice, please call us at 1-800-722-1471.