



12401 E. Marginal S., Tukwila, WA 98168
P.O. Box 34750, Seattle, WA 98124-9745

Employee enrollment and change form

EMPLOYER: PLEASE COMPLETE THIS SECTION

Coverage effective date _____ Original date of hire ___/___/___ **Choose one:**
 Group name _____ Date of rehire ___/___/___ Open enrollment New employee
 Group number _____ Date transferred from part (p/t) to full time (f/t) ___/___/___ Address/name change Add dependent(s)
 *Group number should match health plan choice, if selected by employee in section below. Remove coverage
 Hours worked per week _____ ___ Subscriber ___ Dependent(s)
 Choose one: Group Health Cooperative Group Health Options, Inc. If retired, date of retirement ___/___/___ Date processed _____ by _____

Transfer to COBRA
 Start date _____
 18 months
 36 months

EMPLOYEE: COMPLETE THE FOLLOWING. PLEASE PRINT.

Employee name _____ (Last name) (First name) (M.I.) Marital status: Single Married Date married ___/___/___
 Mailing address _____ Home phone () _____
 Resident address _____ (Street) (City) (State) (Zip) Work phone () _____
 Employee Medicare claim # _____ Former name of applicant or spouse _____
Health plan choice *If more than one health plan is offered, please write in your choice, including the group number.*
 Health plan _____ *Group number _____

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.

FOR HEALTH PLAN INTERNAL USE ONLY	CHECK ONE		PLEASE PRINT LAST NAME	FIRST NAME	M.I.	SOCIAL SECURITY NUMBER	MALE/FEMALE	BIRTHDATE (MM/DD/YY)	RELATIONSHIP TO EMPLOYEE
	ADD	REMOVE							
			SELF						
			DEPENDENT						
			DEPENDENT						
			DEPENDENT						
			DEPENDENT						

Please list names of any **dependents who are Medicare-eligible or disabled and their Medicare number:**

1. Spouse Medicare claim # _____ 2. Dependent name _____ 3. Medicare claim # _____

ADDITIONAL HEALTH BENEFITS INFORMATION

Other insurance (that is not Group Health Cooperative or Group Health Options, Inc.): _____
 Who is the subscriber under this plan? _____
 What is their social security or policy number with this plan? _____ Attach any certificate of creditable coverage letters to the back of this form.

(Signature of employee) **(Date signed)**

Please retain a copy for your records