AGC Health Benefit Trust
ALASKA WASHINGTON CHAPTERS

EMPLOYEE ENROLLMENT FORM

Group Name: _____

EMPLOYER INFORMATION (TO BE COMPLETED BY HR)		
Enrollment (check one): ❑ New Enrollment ❑ Change of Enrollment Status		Effective Date of Insurance/Change:
Enrollment/Change Reason: ❑ New Employee ❑ Rehired Employee ❑ Open Enrollment ❑ Transfer from Other Plan ❑ Involuntary Loss of Other Coverage (Prior Coverage Certificate required) ❑ Marriage ❑ Divorce ❑ Adoption (Legal Documents May be Required) ❑ Dependent Change Date of Event:		
Date of Hire:	Date Employee Entered Eligible Class (if not date of hire):	Employee Class:
Employee Hours Worked Per Week:	Job Title:	

EMPLOYEE INFORMATION (TO BE COMPLETED BY EMPLOYEE)			
Employee Name:		Phone:	
Mailing Address:	City:	State:	Zip:

Add	Drop	Relationship to Employee	Name (Last, First, MI)	Social Security Number (required)	Date of Birth	Gender		Primary Care Physician
						Male	Female	(required for Navigate and Select plan elections)
❑	❑	Self						
❑	❑	Spouse/Domestic Partner						
❑	❑							
❑	❑							
❑	❑							
❑	❑							
❑	❑							
❑	❑							
❑	❑							
❑	❑							

Is any child, over the dependent age limit of 26, applying for coverage due to disability? ❑ No ❑ Yes If yes, see Human Resources for additional paperwork.

GROUP MEDICAL / RX - EMPLOYEE PLAN SELECTION					
United Healthcare of Washington, Inc.	❑ Employee Only	❑ Employee + Spouse	❑ Employee + Child(ren)	❑ Employee + Family	❑ Decline
	Product Selection – Choose one plan only:				
	❑ Premier 250 ❑ Premier 500 ❑ Premier 1000 ❑ Premier 1500 ❑ Premier 2000	❑ Preferred 1000 ❑ Preferred 2000 ❑ Preferred 2500 ❑ Preferred 3000 ❑ Preferred 5000	❑ Primary Advantage 2000 ❑ HSA 1500 ❑ HSA 2000 ❑ HSA 3500 ❑ HSA 5000	❑ Select Plus 500 ❑ Select Plus 1000 ❑ Select Plus 1500 ❑ Select Plus 2000 ❑ Select Plus 2500	❑ Navigate 500 ❑ Navigate 1750 ❑ Navigate 2500 ❑ Navigate 3500
ANCILLARY BENEFITS - EMPLOYEE PLAN SELECTION (If offered by employer, complete where applicable.)					
Group Dental – Delta Dental of WA	❑ Employee Only	❑ Employee + Spouse	❑ Employee + Child(ren)	❑ Employee + Family	❑ Decline
Group Vision – Standard Insurance	❑ Employee Only	❑ Employee + Spouse	❑ Employee + Child(ren)	❑ Employee + Family	❑ Decline

Beneficiary for Employee's Group Life/AD&D Insurance:

Beneficiary Name	Relationship	Address	Benefit %

I authorize UnitedHealthcare of Washington, Inc. and its affiliates (collectively, "UnitedHealthcare") to obtain, use and disclose my medical, claim or benefit records, including any individually identifiable health information contained in these records. I understand these records may contain information created by other persons or entities (including health care providers) as well as information regarding the use of drug, alcohol, HIV/AIDS, mental health (other than psychotherapy notes), sexually transmitted disease and reproductive health services. I authorize any health care provider, pharmacy benefit manager, other insurer or reinsurer, hospital, clinic or other medical facility, health care clearinghouse, and any of their affiliates, representatives or business associates, to disclose my information to UnitedHealthcare and Affiliates. I understand that the purpose of the disclosure and use of my information is to allow UnitedHealthcare to facilitate the appropriate management of treatment, services, payment and benefits. I further understand that the information disclosed will not be used for purposes of eligibility, enrollment, underwriting and premium risk rating. I understand this authorization is voluntary and I may refuse to sign the authorization. I understand I may revoke this authorization at any time by notifying my UnitedHealthcare representative in writing, except to the extent that action has already been taken in reliance on this authorization. Send the revocation of authorization to UnitedHealthcare of Washington, Inc. at 1111 3rd Avenue, Suite 1100, Seattle, WA 98101, ATTN: UHC of WA, Inc. plan representative. As required by HIPAA, UnitedHealthcare also requires that I acknowledge the following, which I do: I understand that information I authorize a person or entity to obtain and use may be re-disclosed and no longer protected by federal privacy regulations. This authorization, unless revoked earlier, expires 24 months after the date it is signed.

I understand that I am completing a joint life and health application and that each response is accurate and truthful to the best of my knowledge. I (we) request the indicated group medical coverage. I authorize any required premium contributions to be deducted from my earnings. I (we) have not given the agent or any other persons any required information not included on the application. I (we) understand that UnitedHealthcare is not bound by any statements I (we) have made to any agent or to any other persons, if those statements are not written or printed on this application and any attachments.

Please note that if you leave out information or make a misrepresentation on this form we may be allowed by law to take one or more of the following actions: terminate or non- renew your coverage or change your premium retroactively to the date your policy became effective. 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. Please maintain a copy of this authorization for your records.

Employee Signature Print Name: Date:

Under the special enrollment provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), employees, particularly those that waive coverage, may be eligible to late enroll in a medical coverage offered under the AGC Health Benefit Trust (the "Trust"), even if they previously declined coverage. This right extends to the employee and all eligible family members.

NOTICE OF SPECIAL ENROLLMENT RIGHTS

If you decline coverage because you have other coverage, you may be eligible to enroll yourself and eligible family members in the Trust if, during the year, you or your family members have a special enrollment event. The following is a list of special enrollment events:

- You or your family member loses coverage in the other plan ended due to termination of employment, divorce/termination of life partnership, death, loss of dependent status or a reduction in hours that affected benefits eligibility;
- You or your family member loses coverage in the other plan ended because you or your dependents no longer live or work in the plan's service area;
- You or your family member loses coverage in the other plan ended because the employer contributions to the plan stopped;
- You or your family member loses coverage in the other plan ended because plan was terminated or discontinued;
- You or your family member's COBRA coverage ended;
- You or your family member ceases being eligible for Medicaid or your state's Children's Health Insurance Program (CHIP) coverage;
- You or your family member become newly eligible for a state premium assistance program for qualifying child to pay for an employer health plan; or
- You acquire a new family member during the year as a result of marriage, birth, adoption or placement for adoption.

Please note that special enrollment rights will be extended only if you notify Benefit Solutions, Inc. at (877) 694-8291 within 30 days of the loss of coverage or acquiring a new family member or within 60 days for ceasing to be eligible Medicaid/CHIP or becoming eligible for State premium assistance.

If you meet any of the above requirements, you will be allowed one of these options:

- Enroll in any medical plan option designated by your employer for which you and your family members are eligible; or
- Enroll your dependents in your current medical coverage.

If you have any questions or concerns please contact Benefit Solutions, Inc. at (877) 694-8291.