

Northwest Employers Trust

Fax to NET Connect at 1-877-225-0463

or process online at www.netplans.net

ENROLLMENT:

- New Employee
- Add Dependent birth / marriage / adoption

Date of Marriage: _____

CANCELLATIONS: (list names below)

Effective Date: _____

- Employee and dependent(s)
- Dependent(s) Only

COBRA: Effective Date: _____

Qualifying Event:

- DC =Dependent Child(ren)
- DV =Divorced
- RH =Reduction in Hours
- TE =Termination
- DE =Death
- DX =Disability Extension
- MI =Medicare Ineligible
- 6 Mo. Extension:**

Effective Date: _____

Group Name: _____ Group #: Med. _____ Dental: _____

Date of Hire: _____ Hours Worked Per Week: _____ Effective Date: _____ Employee Class: _____

Name (Last, First, Middle Initial): _____

Home Address: _____

City: _____ State: _____ Zip: _____ Phone Number: _____

Group Administrator Signature: _____ Date: _____

Select a Medical Plan: *Underwritten by Asuris Northwest Health (PO Box 91130, Seattle, WA 98111)*

\$500 Ded PPO \$750 Ded PPO \$1000 Ded PPO \$1500 Ded PPO

\$2000 Ded PPO \$2500 Ded PPO HSA \$1500 Ded

Enroll in Dental Plan: *Underwritten by United Concordia (2200 Sixth Ave. #804, Seattle, WA 98121)*

Last Name	First	M.I.	Relationship	Birth Date	Sex	Social Security Number
			Self			
			Spouse / DP			
			Child			
			Child			
			Child			
			Child			

Have you or any of your dependents applying for medical coverage with Asuris Northwest Health had medical coverage (currently or within the past 3 months) with any health care plan?

Yes No

If you or any of your dependents currently or within the past 3 months with ANY health care plan , you MUST complete the following information:

Other Insurance: Company: _____ Policy Holder's Name: _____ Policy #: _____

Date Coverage Began: _____ Date Coverage Ended: _____ Person(s) Covered: _____

If you are enrolled in Medicare: Enrollment Date: Part A: _____ Part B: _____ Medicare HIC # with Alpha Suffix: _____

Reason for Medicare Coverage:: Disability Over Age 65 End Stage Renal Disease

Life and AD&D Insurance: Underwritten by Regence Life & Health (PO Box 1271, Portland, OR 97207) Group Term Life Insurance Beneficiary Description:

	Name	Soc Sec #	Relationship	Date of Birth	Address	% (Percent)
Beneficiary						
Contingent Beneficiary						

Refusal of Insurance: I understand that if I refuse coverage, my ability to obtain benefits under NET health plans may be restricted by the guidelines set forth by the company.

I have been offered coverage, but I am declining the coverage because: I am covered by another health plan through a spouse or parent (**proof of other coverage required**)

I am covered by Medicare as primary (**proof required**) I am covered by TRICARE/CHAMPUS (**proof required**) I do not wish to enroll in medical I do not wish to enroll in dental

I hereby verify that all of the information specified above is accurate and complete. I have also read and understood the Application Agreement and Release of Information on the reverse side of this application.

Applicant's Signature: X _____ **Date:** _____

APPLICATION AGREEMENT

I hereby apply for enrollment or change of enrollment as indicated on this application. I understand that the Northwest Employers Trust and the Insurers may collect, use and disclose protected health information about each individual enrolled under this application in order to carry out their routine business functions, including but not limited to, determining eligibility for benefits, paying claims, coordinating benefits with other insurance carriers or payer, underwriting and conducting case management care management and quality reviews. The Northwest Employers Trust and the Insurers may also disclose protected health information to state and federal agencies, or other third parties, as required by law.

ANTI-FRAUD PROVISION

I have provided these answers as part of the application procedure required by the issuer to enroll in coverage and I certify that all information completed on this form is true, correct, and complete. I understand that the issuer 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 purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

RELEASE OF INFORMATION

I acknowledge and understand my health plan 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) 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 acknowledgement does not apply to obtaining information regarding psychotherapy notes. A separate authorization will be used for psychotherapy notes. *For more information about such uses and disclosures, including uses and disclosures required by law, please refer to the Notice of Privacy Practices. A copy is available from the Asuris Northwest Health Web site at www.asurisenorthwesthealth.com or by phone at 1-888-344-5587.