P.O. Box 3048, MS 737
Spokane, WA 99220-3048
www.premera.com

MEMBER ENROLLMENT AND CHANGE APPLICATION

Please print as clearly as possible to avoid delays in processing your application

1. GROUP INFORMATION (to be completed by the group)

Group ID	Group name	Employee class/subgroup (as applicable)	Employee hire date / /
Enrollment Reason	If COBRA, indicate number of months eligible for coverage: ☐ 18 months ☐ 29 months ☐ 36 months	Date of enrollment details ☐ Same as hire date ☐ Other date / /	Plan start date / /

2. EMPLOYEE INFORMATION (employee to complete sections 2 through 4)

Employee name (Last) (First)	Contact phone ( )	Contact email (Required*)
Mailing address City State ZIP		

3. ENROLLMENT INFORMATION

Plan choice (as applicable)

NOTE: *Please write names as you would like them to appear on the ID card.* ***ID card names are limited to 26 characters and spaces.***

Add	Drop	Relationship to Employee	Last Name	First Name	Social Security No. (Required*)	Date of Birth	Gender		Benefit Selection	
							Male	Female	Medical	Dental
☐	☐	Self				/ /	☐	☐	☐	☐
☐	☐					/ /	☐	☐	☐	☐
☐	☐					/ /	☐	☐	☐	☐
☐	☐					/ /	☐	☐	☐	☐

If any dependent has a different mailing address, please attach that information. Additional information attached? ☐ No ☐ Yes

If any child over the dependent age limit is applying for coverage due to disability, please complete and attach a ***Request for Certification of Disabled Dependent*** form.

Please complete and attach the ***Other Coverage Questionnaire*** form if any applicant has other current health coverage, including Medicare or Premera, which will remain in effect when your Premera coverage begins. If the form is not included, then it is assumed that no other coverage is in effect.

4. 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 section 5 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.*

An Independent Licensee of the Blue Cross Blue Shield Association

Delta Dental of Washington

PO Box 75688 | Seattle WA 98175-0688
(206) 528-5335 or (800) 572-7835 x 5335

Enrollment Form

DDWA Small Business Plans

☐ New ☐ Change ☐ Open Enrollment ☐ COBRA ☐ Reinstate ☐ Other (Check One)

Employer or Group Name	Group Number	Subgroup	Hire Date	Effective Date	
Social Security Number	First Name	Middle Initial	Last Name	Birthdate	Gender
Address		City	State	Zip	
Phone Number		Email Address			

Dependents

Please list all dependents to be covered:

First Name	Middle Initial	Last Name	Birthdate	Gender	Add/ Remove	Dependent Over Limiting Age Verification*
Spouse or Domestic Partner**				M ☐ F ☐	Add ☐ Remove ☐	
Dependent				M ☐ F ☐	Add ☐ Remove ☐	Incapacitated*** ☐
Dependent				M ☐ F ☐	Add ☐ Remove ☐	Incapacitated*** ☐
Dependent				M ☐ F ☐	Add ☐ Remove ☐	Incapacitated*** ☐
Dependent				M ☐ F ☐	Add ☐ Remove ☐	Incapacitated*** ☐

Coordination of Benefits

Do any of your dependents have other dental coverage? Yes ☐ No ☐ If yes, please complete the section below.

Employer Group Number and Name			Effective Date		
Name and Address of Other Insurance Carrier					
Social Security Number	First Name	Middle Initial	Last Name	Birthdate	Gender

COBRA Enrollment Only

Indicate Qualifying Date
Indicate Qualifying Event ☐ Termination ☐ Reduction in Hours ☐ Divorce ☐ Widowed/Surviving Dependent ☐ Dependent Child No Longer Eligible ☐ Other

Continued on back ▸▸

Waiver Dental Coverage

I certify that I have been advised of the features and benefits of the dental plan offered to me through my employer and after due consideration, I have chosen:

- ☐ Not to enroll my spouse in the group dental plan being offered by my employer.
- ☐ Not to enroll my children in the group dental plan being offered by my employer
- ☐ Not to enroll myself and my dependents in the group dental plan being offered by my employer. I understand that by taking this action, I waive all benefits payable thereunder for myself and/or my dependents.

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 (R.C.W. 48.135.080).

* The minimum limiting age is through age 25 for all children; coverage shall not terminate for children over the age of 25 who are both (1) incapable of self-sustaining employment by reason of developmental disability or physical handicap and (2) chiefly dependent upon the employee or member for support and maintenance

** Domestic partners include state-registered partnerships and/or other domestic partners if specifically covered by group.

*** Documentation is required (pursuant to R.C.W. 48.44.210). To download the proof of incapacity and dependency form, visit the Delta Dental of Washington website at www.DeltaDentalWA.com/forms.

Signature ____________________ Date ____________

Please return completed form to:

Northwest Administators, Inc.
2323 Eastlake Ave E Seattle WA 98102
1 (800) 932-4790

Service Employees Health and Welfare Trust

Beneficiary Designation Form – Life and AD&D Insurance Benefits

Please see your Summary Plan Description or contact the Trust for benefit eligibility requirements.

Please print in blue or black ink; complete all information requested.

Employer Name			**Group Number** WA 05513W
☐ New Designation ☐ Change of Existing Designation			
Participant's Name (Last, First MI)	Date of Birth	☐ M ☐ F	Social Security Number

Primary Beneficiary (Last, First MI)	Date of Birth	☐ M ☐ F	Social Security Number
Beneficiary Address (Street, City, State and Zip)	Relationship To You		**Benefit %**
Primary Beneficiary (Last, First MI)	Date of Birth	☐ M ☐ F	Social Security Number
Beneficiary Address (Street, City, State and Zip)	Relationship To You		**Benefit %**

If Primary Beneficiary(ies) dies before you, the benefit will be paid to your Contingent Beneficiary(ies).

Contingent Beneficiary (Last, First MI)	Date of Birth	☐ M ☐ F	Social Security Number
Beneficiary Address (Street, City, State and Zip)	Relationship To You		**Benefit %**
Contingent Beneficiary (Last, First MI)	Date of Birth	☐ M ☐ F	Social Security Number
Beneficiary Address (Street, City, State and Zip)	Relationship To You		**Benefit %**

If you wish to name additional beneficiaries, please attach a separate piece of paper with all of the necessary information, including the date and your signature.

The above beneficiary designation applies to life and AD&D insurance benefits under the Service Employees Health and Welfare Trust

Sign, date and return this form to the Trust.

Signature of Participant	**Date Signed**

This form is not valid until SIGNED AND DATED and returned to Northwest Administrators

Please return completed form to:

Northwest Administators, Inc
2323 Eastlake Ave E Seattle WA 98102
1 (800) 932-4790

Instructions for Completing Your Beneficiary Designation

The Primary Beneficiary(ies) you select receives the benefit proceeds upon your death. The Contingent Beneficiary(ies) you select receives proceeds only if the Primary Beneficiary(ies) dies before you. You may have more than one Primary or Contingent Beneficiary. If so, please provide all requested information, and the percentage of proceeds you would like each Beneficiary to receive. If no beneficiary is named, or no beneficiary survives you, settlement will be made in accordance with the terms of the insurance contract. Please provide all requested information.

Examples follow:

A. One Primary Beneficiary:	Mary R. Jones – 100% (list information)
B. Two or more Primary Beneficiaries:	50% to John Jones and 50% to Sally Smith (list information for both)
C. Two or more Primary Beneficiaries in Unequal Shares:	75% to John Jones and 25% to Sally Smith (list information for both)
D. One Primary and Contingent Beneficiary:	100% to Mary R. Jones, if living, otherwise to Sally Smith (list info. for both)
E. Trustee:	Mary R. Jones, Trustee, under trust agreement dated _______
F. Insured's Estate:	My Estate

Under items B. and C. above, if one of the Primary Beneficiaries dies before you, 100% of the proceeds will go to the living Primary Beneficiary(ies).

Do you know that if death occurs and a minor (a person not of legal age) is the beneficiary, it may be necessary to have a Guardian of the Estate of the minor, or a Conservator for the minor appointed before any death benefit can be paid? This means legal expenses for the beneficiary and delay in the payment of the insurance. Please take this into consideration when naming your beneficiary.

If you have any questions, please contact the Trust at 1 (800) 932-4790.

P.O. Box 91059
Seattle, WA 98111-9159

PREMERA | BLUE CROSS

Affidavit of Domestic Partnership – Group Plans

1. Domestic Partners

A. Only domestic partnerships not documented in a state registry must complete this affidavit.

B. I, ______________________ certify that I, and ______________________
Print Name of Employee — Print Name of Domestic Partner

are domestic partners, and we:

1. currently share the same regular and permanent residence, and
2. have a close personal relationship, and
3. are jointly responsible for "basic living expenses" as defined below, and
4. are not married to anyone, and
5. are each eighteen (18) years of age or older, and
6. are not related by blood closer than would bar marriage in Washington state, and
7. were mentally competent to consent to contract when our domestic partnership began, and
8. are each other's sole domestic partner and are responsible for each other's common welfare.

C. "Basic living expenses" means the cost of basic food, shelter, and any other expenses of a domestic partner. The individuals need not contribute equally or jointly to the cost of these expenses as long as they agree that both are responsible for the cost.

2. Employee

A. I understand that this Affidavit shall be terminated upon the death of my domestic partner or by a change in the circumstance attested to in this Affidavit.

B. I agree to notify the Business Office if there is any change in circumstances attested to in this Affidavit within thirty (30) days of the change.

C. After such termination, I understand that another Affidavit of Domestic Partnership cannot be filed within _________ as determined by the Group, but in no case more than 60 days, after a request for termination of domestic partnership has been filed with the Business Office.

3. Agreement

A. We understand that this information will be held confidential and will be subject to disclosure only to Premera Blue Cross for purposes of confirming our eligibility or upon our written authorization or as required by law.

B. We understand that this declaration of responsibility for our common welfare may have legal implications under Washington law.

C. We understand that a civil action may be brought against us for any losses, including reasonable attorney's fees, because of a false statement contained in this Affidavit of Domestic Partnership.

D. We also certify under penalty of perjury, under the laws of the State of Washington, that the foregoing is true and correct.

E. I, the undersigned Employee, understand that willful falsification of information on this Affidavit may lead to disciplinary action, up to and including discharge from employment.

______________________ Signature of Employee

______________________ Signature of Domestic Partner

_____/_____/_____ Date Signed (MM/DD/YYYY)

_____/_____/_____ Date Signed (MM/DD/YYYY)

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 coverage.

Note to Group: Keep original for your file and only submit a copy of the updated enrollment application to Premera Blue Cross.