EVERGREEN SECURITY TRUST

EMPLOYEE ENROLLMENT APPLICATION

administered by Benefit Solutions, Inc.

12121 Harbour Reach Dr, Suite 105 – Mukilteo, WA 98275
PO Box 6 – Mukilteo, WA 98275

Effective Date of Enrollment, Termination or Change:	/01/	Employer Name:		Employer #	
				Class	

Check One ☐ New Enrollee ☐ Address Change ☐ Add Dependents ☐ Delete Dependents ☐ Name Change ☐ Life Insurance Only

PERSONAL INFORMATION: (PLEASE PRINT CLEARLY)

Employee Name:	LAST FIRST MIDDLE			**SSN:**	
				Date of Birth:	
Address:				**Hire Date:**	_____ / _____ / ________
City:		**State:**		**Zip:**	
Phone:	( )	Marital Status:	Date of Marriage:	**Sex:**	☐ Male ☐ Female

MEDICAL COVERAGE IS UNDERWRITTEN BY ASURIS NORTHWEST HEALTH
528 E. SPOKANE FALLS BLVD., STE. 301 - SPOKANE, WA 99202

DENTAL COVERAGE IS UNDERWRITTEN BY WASHINGTON DENTAL SERVICE
9706 4TH AVENUE NE - SEATTLE, WA 98115

DEPENDENT ENROLLMENT: If you are a NEW ENROLLEE, list below any dependents you wish to cover. If you are changing the status of your dependents, please list all dependents and mark the ADD or DELETE boxes accordingly for each dependent:

Name of Dependent	Birthdate	Relationship to Employee	Sex	SSN	
1).		☐ Spouse ☐ Son ☐ Daughter	☐ Male ☐ Female		☐ Add ☐ Delete
2).		☐ Spouse ☐ Son ☐ Daughter	☐ Male ☐ Female		☐ Add ☐ Delete
3).		☐ Spouse ☐ Son ☐ Daughter	☐ Male ☐ Female		☐ Add ☐ Delete
4).		☐ Spouse ☐ Son ☐ Daughter	☐ Male ☐ Female		☐ Add ☐ Delete

PRIOR COVERAGE and **COORDINATION OF BENEFITS**

If you or your dependents HAD medical or dental coverage in the last 3 calendar months, provide info below.

❑ Check here if you have a "Certificate of Credible Coverage" from your prior plan (enclose a copy for each enrollee).

IF YOU OR ANY DEPENDENT CURRENTLY HAS OTHER GROUP MEDICAL OR DENTAL COVERAGE (INCLUDING MEDICARE), PLEASE COMPLETE BELOW:

Medical	Dental	Name of Family Member	Other Employer (or Medicare)	Date Coverage Began	Date Coverage Ended	Name of Insurance and/or Policyholder Name	Plan Number
❑	❑						
❑	❑						
❑	❑						
❑	❑						
❑	❑						

LIFE / AD&D COVERAGE IS UNDERWRITTEN BY REGENCE LIFE & HEALTH
PO BOX 1271, MS E3A - PORTLAND, OR 97207

BENEFICIARY FOR BASIC LIFE / AD&D INSURANCE BENEFIT ***Attach an additional sheet if more than one beneficiary is designated.***

Name:		**Relationship:**	
Address:			

By signing below, I acknowledge that I have read, understand and agree to the Terms & Conditions on all pages of this form.

Employee Signature	**Date**
Employer Signature	**Date**

Form must be submitted to Trust Office by Employer.

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EVERGREEN SECURITY TRUST - TERMS & CONDITIONS

APPLICATION AGREEMENT

I hereby apply for coverage under the contract between Asuris Northwest Health (the company) and my employer or group, and I agree with the terms of the contract. I also apply for the same coverage for my spouse and/or my dependent children listed on this application. I certify that my listed dependents and I meet all the eligibility criteria set forth in the outline of benefits and/or the contract. I agree to pay in advance the appropriate rates for myself and listed dependents and authorize rate increases as the company deems necessary.

ANTI-FRAUD STATEMENT

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. For the protection of all of our members, fraud or misrepresentation of material fact by me for the purposes of defrauding the issuer may result in the issuer taking any action allowed by law or Contract, including termination or rescission of coverage, denial of benefits, and/or pursuit of criminal charges and penalties.

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.asuris.com or by phone at 1-888-344-5593.