



EVERGREEN SECURITY TRUST

administered by Benefit Solutions, Inc.

EMPLOYEE ENROLLMENT APPLICATION

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 # | | |
| Check One | | <input type="checkbox"/> New Enrollee <input type="checkbox"/> Address Change <input type="checkbox"/> Add Dependents <input type="checkbox"/> Delete Dependents <input type="checkbox"/> Name Change <input type="checkbox"/> Life Insurance Only | | | | | |
| PERSONAL INFORMATION: (PLEASE PRINT CLEARLY) | | | | | | | |
| Employee Name: | LAST FIRST MIDDLE | | | SSN: | | | |
| Address: | | | | Date of Birth: | | | |
| City: | | | | Hire Date: | ____/____/____ | | |
| Phone: | () | Marital Status: | Date of Marriage: | State: | Zip: | | |
| | | | | | Sex: | <input type="checkbox"/> Male <input type="checkbox"/> Female | |
| MEDICAL COVERAGE IS UNDERWRITTEN BY REGENCE BLUESHIELD | | | | | | | |
| 1800 NINTH AVENUE - PO BOX 21267 - SEATTLE, WA 98111-3267 | | | | | | | |
| DENTAL COVERAGE IS UNDERWRITTEN BY WASHINGTON DENTAL SERVICE | | | | | | | |
| 9706 4TH AVENUE NE - SEATTLE, WA 98115 | | | | | | | |
| PLEASE NOTE: If "SELECTIONS" plan is offered by the employer, the employee must provide PRIMARY CARE PHYSICIAN (PCP) NAME and PRIMARY CARE PHYSICIAN (PCP) NUMBER for each Plan enrollee, including dependents. | | | | | | | |
| Employee PCP Provider: | | PCP #: | Is Patient Established with PCP? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | |
| 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). | | | <input type="checkbox"/> Spouse <input type="checkbox"/> Son <input type="checkbox"/> Daughter | <input type="checkbox"/> Male <input type="checkbox"/> Female | | <input type="checkbox"/> Add <input type="checkbox"/> Delete | |
| PCP Provider: | | PCP # | Is Patient Established with PCP? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | |
| 2). | | | <input type="checkbox"/> Spouse <input type="checkbox"/> Son <input type="checkbox"/> Daughter | <input type="checkbox"/> Male <input type="checkbox"/> Female | | <input type="checkbox"/> Add <input type="checkbox"/> Delete | |
| PCP Provider: | | PCP # | Is Patient Established with PCP? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | |
| 3). | | | <input type="checkbox"/> Spouse <input type="checkbox"/> Son <input type="checkbox"/> Daughter | <input type="checkbox"/> Male <input type="checkbox"/> Female | | <input type="checkbox"/> Add <input type="checkbox"/> Delete | |
| PCP Provider: | | PCP # | Is Patient Established with PCP? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | |
| 4). | | | <input type="checkbox"/> Spouse <input type="checkbox"/> Son <input type="checkbox"/> Daughter | <input type="checkbox"/> Male <input type="checkbox"/> Female | | <input type="checkbox"/> Add <input type="checkbox"/> Delete | |
| PCP Provider: | | PCP # | Is Patient Established with PCP? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | |
| 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. | | | | | | | |
| <input type="checkbox"/> 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 |
| <input type="checkbox"/> | <input type="checkbox"/> | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | | | | | | |
| 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 |

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Form must be submitted to Trust Office by Employer.

EVERGREEN SECURITY TRUST - TERMS & CONDITIONS

APPLICATION AGREEMENT

I hereby apply for coverage under the contract between Regence BlueShield (the company), an independent licensee of the Blue Cross and Blue Shield Association, 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 Regence BlueShield Web site at www.wa.regence.com or by phone at 1-800-458-3523 or 1-206-464-3663.