



12401 E. Marginal S., Tukwila, WA 98168
P.O. Box 34750, Seattle, WA 98124-9745

Employee Enrollment and Change Form

EMPLOYER: PLEASE COMPLETE THIS SECTION

Coverage Effective Date _____	Original Date of Hire ____/____/____	Choose one: <input type="checkbox"/> Open Enrollment <input type="checkbox"/> New Employee <input type="checkbox"/> Address/Name Change <input type="checkbox"/> Add Dependent(s) <input type="checkbox"/> Remove Coverage ___ Subscriber ___ Dependent(s) Date Processed _____ By _____	<input type="checkbox"/> Transfer to COBRA Start Date _____ <input type="checkbox"/> 18 months <input type="checkbox"/> 36 months
Group Name _____	Date of Rehire ____/____/____		
Group Number _____	Date Transferred From Part (P/T) to Full Time (F/T) ____/____/____		
<i>*Group number should match health plan choice, if selected by employee in section below.</i>	Hours Worked Per Week ____/____/____		
Choose one: <input type="checkbox"/> Group Health Cooperative <input type="checkbox"/> Group Health Options, Inc.	If Retired, Date of Retirement ____/____/____		

EMPLOYEE: COMPLETE THE FOLLOWING. PLEASE PRINT.

Employee Name _____ (Last Name) _____ (First Name) _____ (M.I.) Marital Status: Single Married Date Married ____/____/____

Mailing Address _____ Home Phone () _____

Resident Address _____ (Street) _____ (City) _____ (State) _____ (Zip) Work Phone () _____

Employee Medicare Claim # _____ Former Name of Applicant or Spouse _____

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.

Health Plan Choice *If more than one health plan is offered, please write in your choice, including the group number.*

*Health Plan _____ Group Number _____

FOR HEALTH PLAN INTERNAL USE ONLY	CHECK ONE		PLEASE PRINT LAST NAME	FIRST NAME	M.I.	SOCIAL SECURITY NUMBER	MALE/ FEMALE	BIRTHDATE (MM/DD/YY)	RELATIONSHIP TO EMPLOYEE
	ADD	REMOVE							
			SELF						
			DEPENDENT						
			DEPENDENT						
			DEPENDENT						
			DEPENDENT						

DEPENDENT ELIGIBILITY INFORMATION Please list names of **married dependents**:

1. _____ (Last Name) _____ (First Name) _____ (M.I.) 2. _____ (Last Name) _____ (First Name) _____ (M.I.)

Please list names of any **dependents who are Medicare-eligible or disabled and their Medicare number**:

1. Spouse Medicare Claim # _____ 2. Dependent Name _____ 3. Medicare Claim # _____

ADDITIONAL HEALTH BENEFITS INFORMATION

Other insurance (that is not Group Health Cooperative or Group Health Options, Inc.): _____

Who is the subscriber under this plan? _____

What is their social security or policy number with this plan? _____ Attach any certificate of creditable coverage letters to the back of this form.

(Signature of Employee)

(Date Signed)

Please retain a copy for your records