



WEA SELECT ENROLLMENT AND CHANGE APPLICATION



School District Name: _____ New Enrollment Change Enrollment

Employee Information

Employee Name (Last) _____ (First) _____ (MI) _____ Premera ID Number (if enrolled) _____ Home Phone _____

Mailing Address _____ City _____ State _____ ZIP _____

Will you or your dependent(s) enrolled on your WEA Select Plan have any other active medical, vision, or Medicare coverage when this coverage begins?
 No Yes, please complete and attach an **Other Coverage Questionnaire** form.

Is any child over the dependent age limit applying for coverage due to a disability? No Yes, complete and attach the **Request for Certification of Disabled Dependent** form.

Medical and Vision Plan Selection and Enrollment (Not all districts or employer groups offer all plans. PLEASE See Enrollment Notes on the reverse side)

Waive WEA Medical WEA Plan 1 WEA Plan 2 WEA Plan 3 WEA Plan 5 WEA EC-A WEA EC-B WEA EC-C
 No WEA Vision Vision Plan A Vision Plan B Vision Plan C Vision Plan D Vision Plan E Vision Plan F

	Please list ALL enrollees to be covered, added or dropped on your plan Note: Names on ID cards are limited to 26 characters and spaces				Gender M / F	Birth Date (Mo., Day, Yr.)	Please check applicable boxes							
	Last Name	First Name	M I	Social Security No.			WEA Medical	Keep	Add	Drop	WEA Vision	Keep	Add	Drop
Self														
Spouse/DP														
Child:														
Child:														
Child:														
Child:														

I declare that to the best of my knowledge, all of the information on this form is true and complete, and all of the persons for whom I am requesting enrollment are eligible for coverage. I have also read and understand the provisions as stated on the reverse side. The changes on this form supersede all previous forms submitted. I authorize my employer to deduct from my earnings the amount, if any, for the coverage selected. If filling out the **online** form, please print two copies of the application—one for your records and one for the school district. If filling out the **4-part form**, keep goldenrod copy and return the others to the district. **Be sure to sign your application before turning it in.**

Employee Signature: X **Date Signed:** _____

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.

To be completed by School District Print a copy for your records if using the online form. Or, send white & yellow copies to Premera; retain pink copy for your records.

Check Appropriate Enrollment Box and Provide Date:

<input type="checkbox"/> New Employee	<input type="checkbox"/> Insurance Eligible	<input type="checkbox"/> Open Enrollment	<input type="checkbox"/> Dependent Change	Date of Qualifying Event / /	Effective Date of Insurance / /
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Change of Status: Marriage/Domestic Partnership Divorce/End of Domestic Partnership Death Surviving Dependents Birth Special Enrollment Full time to Part Time

Discount rate **Legal documentation is attached for:** Adoption Medical Child Support Order Legal Guardianship/Non-parental Custody

Full rate **Loss of Other Coverage—Reason:** _____ **Date Prior Coverage Ended:** / /

Premera Blue Cross Use Only ID Number: _____ ID Card: _____ Date: / / Initials: _____

PREMERA PRIVACY POLICY PRACTICES

We may collect, use, or disclose personal information about you, including health information, your address, telephone number or Social Security number. We may receive this information from, or release it to, healthcare providers, insurance companies, or other sources to conduct our routine business operations such as: underwriting and determining your eligibility for benefits and paying claims; coordinating benefits with other healthcare plans; conducting care management, case management, or quality reviews. This information may also be collected, used or released as required or permitted by law.

To safeguard your privacy and ensure your information remains confidential, we train all employees on our written confidentiality policy and procedures. If a disclosure of your personal information is not related to a routine business function, we will remove anything that could be used to easily identify you, unless we have your prior authorization to release such information.

You have the right to request inspection and/or amendment of your records retained by us.

To view or print copies of our detailed Privacy Notice and other forms, please visit our web site at www.premera.com/wea. To have forms mailed to you, please call the WEA Select Service Team at 1-800-932-9221.

ENROLLMENT NOTES

- Complete all sections of the WEA Select Enrollment and Change Application except the portion that is reserved for use by your school district and Premera Blue Cross.
- List ALL eligible family members to be covered, added or dropped on your plan and check the appropriate box to the right of each name.
- Please indicate each dependents name on the enrollment application as you would like it to appear on the ID card.
Note: ID card names are limited to a maximum of 26 characters and spaces.
- If you have dependents that are to be enrolled on a WEA Select Vision plan but are not covered on your WEA Select Medical plan, please indicate that by checking the appropriate vision box to the right of each dependents name.

Medical plan selection and enrollment (Underwritten by Premera Blue Cross, PO Box 327, Seattle, WA 98111)

Please choose only from the plans made available to you by your school district or employer group. Not all school districts offer all six WEA Select sponsored medical plans. Contact your payroll office or benefits administrator for more information. If you are enrolling only on a WEA Vision plan, check the **Waive WEA Medical** box under **Medical and Vision Plan Selection and Enrollment**.

Vision plan selection and enrollment (Underwritten by Premera Blue Cross. Plans B, C, E & F administered by Vision Service Plan (VSP), PO Box 997105, Sacramento, CA 95899). Not all school districts and employer groups offer WEA Select Vision Plans. Contact your payroll office or benefits administrator for more information. Please check the appropriate box for the vision plan offered to you by your district or employer group under **Medical and Vision Plan Selection and Enrollment**. If a WEA Select vision plan is not available, please check **No WEA Vision**.

Vision subscription rates

The employee and all eligible dependents are covered for one monthly charge regardless of the number of dependents covered. Please list ALL eligible family members to be enrolled on your WEA Select Vision Plan on the enrollment application.

For additional information on dependent eligibility, refer to your benefit booklet or go to www.premera.com/wea.