PREMERA BLUE CROSS

Mail to:
P.O. Box 327, MS 737
Seattle, WA 98111-0327
www.premera.com

SMALL GROUP MEMBER ENROLLMENT AND CHANGE APPLICATION

Group ID	Group name	Employee class/subgroup (as applicable)	Employee date of hire / /
Enrollment reason	If COBRA, indicate number of months for coverage: ☐ 18 months ☐ 29 months ☐ 36 months COBRA reason: _____	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 e-mail (*Required)
Mailing address	City	State ZIP	

3. ENROLLMENT INFORMATION

Plan choice (as applicable)

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

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

PersonalCare Partner System (only required for PersonalCare Plan):_____ _____

Ethnicity (Optional)	(Check All That Apply)	(Check All That Apply)	Primary Language	Secondary Language
	☐ American Indian ☐ Asian ☐ Black African American ☐ Native Hawaiian/Pacific Islander	☐ Hispanic/Latino ☐ Not Hispanic or Latino ☐ White	☐ English ☐ Spanish ☐ Other_____	☐ English ☐ Spanish ☐ Other_____

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

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

PersonalCare Partner System (only required for PersonalCare Plan):_____ _____

Ethnicity (Optional)	(Check All That Apply) ☐ American Indian ☐ Asian ☐ Black African American ☐ Native Hawaiian/Pacific Islander	(Check All That Apply) ☐ Hispanic/Latino ☐ Not Hispanic or Latino ☐ White	Primary Language ☐ English ☐ Spanish ☐ Other_____	Secondary Language ☐ English ☐ Spanish ☐ Other_____

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

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

PersonalCare Partner System (only required for PersonalCare Plan):_____ _____

Ethnicity (Optional)	(Check All That Apply) ☐ American Indian ☐ Asian ☐ Black African American	(Check All That Apply) ☐ Hispanic/Latino ☐ Not Hispanic or Latino	Primary Language ☐ English ☐ Spanish ☐	Secondary Language ☐ English ☐ Spanish ☐ Other_____

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

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. ☐ Yes ☐ No

4. NOTICES

PREMERA PRIVACY POLICY

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; or 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 website at premera.com. To have forms mailed to you, please call the number below.

SPECIAL ENROLLMENT RIGHTS

If you are declining enrollment for yourself or dependents because of other healthcare coverage, you may in the future enroll yourself or your dependents in this plan prior to the next open enrollment period. To do this, you must have involuntarily lost your other coverage and we must receive your enrollment application within 60 days after your other coverage ended (60 days if the prior coverage was through Medicaid or CHIP). Additionally, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and dependents, provided we receive your completed enrollment application within 60 days after the marriage, birth, adoption, or placement for adoption, unless a different time limit has been specified in your benefit booklet.

LATE ENROLLEES

A late enrollee is an individual or family dependent who did not enroll when first eligible for coverage under this plan. A late enrollee does not qualify as a special enrollee. If you or your dependents are late enrollees, you or your dependents may enroll during the next annual group enrollment period.

STATE CONTINUATION OF COVERAGE

If you are enrolling under State Continuation of Coverage (COC), the eligible period of coverage cannot exceed 3 months

*** REQUIRED SOCIAL SECURITY NUMBER AND CONTACT EMAIL ADDRESS**

Under the Affordable Care Act (ACA), all health plans must provide an IRS Form 1095-B to fully insured members starting in 2016. You'll need Form 1095-B to help you file your taxes, much like your W-2.

If you have any questions about the information included in this notice, please call us at 1-800-722-1471.

5. 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.