**Associated Employers Trust – Commercial Construction Health and Welfare Trust**

**Employee Enrollment & Change Form 2014**

## 1. Group Information (to be completed by the group) Please Be Sure To Fill Out All Highlighted Sections

Group Name:

Effective Date: _____

Date of Hire: _____

Rate of Pay and Amount: $ _____ per

☐ Yr ☐ Mo ☐ Bi-Wk ☐ Wk ☐ Hr

☐ **New** ☐ **Change (Mark Reason Below)** **COBRA CARRY-OVER ELECTION MUST USE COBRA CARRYOVER APPLICATION TO ENROLL.**

☐ Hire/Rehire ☐ Open Enrollment ☐ Loss of Prior Coverage ☐ Address/Name Change ☐ Add or ☐ Remove Dependent(s)

Date:_____ Reason _____

☐ **Termination**

Last day Worked _____ Last day Compensated _____ Date Coverage Ends _____

☐Voluntary ☐Involuntary of Coverage

## 2. Employee Information (employee to complete sections 2 through 6) Please print legibly and sign Application

| Employee Name: (Last, First, MI) | **Date of Birth**:_____ Gender: ☐ Male ☐ Female | ☐ Married ☐ Unmarried | Social Security # - - | Home Phone: ( ) - | Worksite Location (State):- |
|---|---|---|---|---|---|

Mailing Address: City State Zip

Employee Email Address:

## 3. Enrollment Information: Please note that an incomplete application may delay processing. Please make sure to print legibly and sign application

☐ I choose to **WAIVE** Medical/Rx coverage due to Medicare Supplement, but elect any ancillary coverage chosen by my employer (i.e. dental, vision). Basic Life not available.

☐ I choose to **WAIVE** the Medical/Rx coverage for myself and my dependents. **Reason for Waiving:** _____

☐ I choose to **WAIVE** dental coverage.

**Medical Plan Choice** (Underwritten by Moda Health Plan, Inc.):

☐ I choose to **ELECT** medical coverage. Plan Selection: _____(Your employer has selected the options available to you. See your benefit administrator for details. Compulsory $15,000 Life/AD&D is included with all medical. Beneficiary is required.)

**Dental Plan Choice** (Underwritten by Delta Dental of Washington): Only available if chosen by your employer.

☐ I choose to **ELECT** dental coverage. Plan Selection: _____(Your employer has selected the options available to you. See your benefit administrator for details.)

**Vision Plan Choice** (Underwritten by Vision Service Plan): Only available if chosen by your employer.

☐ I choose to **ELECT** vision coverage. Plan Selection: _____(Your employer has selected the options available to you. See your benefit administrator for details.)

**Supplemental Employee and Dependent Life and AD&D** Underwritten by Standard Insurance Company (Only available if chosen by your employer) Supplemental Employee Life/AD&D coverage. ☐ Yes ☐ No

IF "YES" for Employee Coverage: Supp Dependent Life/AD&D for Spouse Only ☐ Yes ☐ No Supp Life for Dependent Child(ren) ☐ Yes ☐ No

Amount of Coverage Requested (Please see your benefit administrator for allowed increments) Employee:_____Spouse: _____

NOTE: In order for dependents to qualify for a benefit selection, the employee must select the same benefit. Please indicate each member's name as you would like it to appear on the ID Card. ID cards are limited to 26 characters and spaces. If dependent has separate mailing address, please attach.

| Add | Drop | Relationship | Last Name | First Name | MI | Social Security No. | Date of Birth | Gender | | Benefit Selection | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | M | F | Med | Dent | Vis |
| ☐ | ☐ | Spouse ☐<br>Domestic Partner ☐* | | | | - - | | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ | ☐ | | | | | - - | | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ | ☐ | | | | | - - | | ☐ | ☐ | ☐ | ☐ | ☐ |
| ☐ | ☐ | | | | | - - | | ☐ | ☐ | ☐ | ☐ | ☐ |

**For individuals who are eligible for enrollment in an employer group health plan:** If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or employer group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if, in the case of employer group health plan coverage, the employer stops contributing toward you or your dependents' other coverage.) However, **the request for enrollment should be received by AIMS within 60 Days after you or your dependents' other coverage ends** (or after the employer stops contributing toward the other coverage). In addition, if you gain a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, we encourage enrollment within 60 days after the marriage, birth, adoption or assumption of a legal obligation for total or partial support of the child in anticipation of adoption. *Domestic Partner coverage is not limited to state registered domestic partners. **If covered dependent has different mailing address, please attach**.

## 4. Prior Medical Coverage (Please complete if you, or any of your dependents, were covered through another health plan in the 90 days prior to the effective date of this coverage)

| | |
|---|---|
| **Prior Coverage? Yes ☐ No ☐** ***(if 'Yes' indicate Prior Coverage below and attach your certificate of creditable coverage)*** | **Duration of Coverage: Effective Date:** _____<br>**Termination Date:** _____ |
| **Prior Medical Carrier and Policy #:** | **List all participants enrolled in prior medical plan:** |

## 5. Coordination of Benefits

| | | | |
|---|---|---|---|
| Other Insurance Carrier: | | Policy ID #: | Effective Date: |
| Policy Holder's Name: | Phone #:<br>( ) - | Date of Birth: | Social Security #:<br>- - |
| If you have Medicare What is the Begin date:<br>_____ | Part A: | Part B: | Medicare HIC # with Alpha Suffix: |

## 6. Designation of Beneficiary

| | | |
|---|---|---|
| **EMPLOYEE BENEFICIARY:** | Primary Beneficiary Name and Relationship* for Basic life/AD&D & Supp. Life/AD&D | Primary Beneficiary Address |
| **EMPLOYEE BENEFICIARY:** | Contingent Beneficiary Name and Relationship** for Basic life/AD&D & Supp. Life/AD&D | Contingent Beneficiary Address |

*** If more than one primary beneficiary is named, the primary beneficiaries shall share equally unless otherwise indicated above.**
**** Contingent Beneficiary(ies) will only receive proceeds if all Primary Beneficiaries have predeceased the Insured. If you are naming more than one Contingent Beneficiary at 100% each, please indicate them in order of precedence.**

## 7. Signature

I hereby apply for enrollment or change of enrollment as indicated on this application. I understand that the Trust and the Health Carriers or Insurers may collect, use and disclose protected health information about each individual enrolled under this application in order to carry out their routine business functions, including but not limited to, determining eligibility for benefits, paying claims, coordinating benefits with other insurance carriers or payer, underwriting and conducting case management care management and quality reviews. The Trust and the Health Carriers and Insurers may also disclose protected health information to state and federal agencies, or other third parties, as required by law. I understand that information collected in connection with administration of the benefit plan may be used to bring to my attention health products or services that might be valuable to me and otherwise as permitted by law. **I agree to accept and/or access all plan documents and notices via electronic delivery.**

I understand that the health benefit plan that I have selected provides reimbursement for certain medical costs, which are more fully described in the current Certificate of Coverage. I understand there may be instances where treatment decisions made by my physician or me or medical expenses which I have incurred may not be covered by my health benefit plan.

The undersigned understands that it is a crime to knowingly provide false, incomplete, or misleading information to a health carrier or insurance company for the purposes of defrauding the company. Penalties include imprisonment, fines and denial of health coverage or other insurance benefits. 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. **Please note: Incomplete applications will delay processing**.

| | |
|---|---|
| Employee Signature **(required for all Adds/Changes to enrollment)** Date: | Employer Signature Date: |

**Please return form to:**
**AIMS 1206 North Lincoln, Suite 200**
**Spokane, WA 99201-2559**
fax to: (509) 777-2690 or
email to **aims@aiin.net**

| | | | | |
|---|---|---|---|---|
| Moda Health Plan, Inc.<br>601 S.W. Second Avenue<br>Portland, OR 97204-3156 | Standard Insurance Company<br>920 SW 6th Avenue<br>Portland, OR 97204 | Delta Dental of Washington<br>9706 Fourth Ave NE<br>Seattle, WA 98115-2157 | Vision Service Plan<br>3333 Quality Dr.<br>Rancho Cordova, CA 9567 | Magellan Health Services<br>14100 Magellan Plaza Drive MO-10<br>Maryland Heights, MO 63043 |