PREMERA | BLUE CROSS

P.O. Box 91059
Seattle, WA 98111-9159
www.premera.com

MEMBER ENROLLMENT AND CHANGE APPLICATION

1. GROUP INFORMATION (to be completed by the group)

Group ID	Group name	☐ New ☐ Change	Reason	Date of event
1038127	**Whitman College**			

Employee class (if applicable)	Employee job title	Employee date of hire	Date employee entered eligible class	Effective date
			☐ Same as hire date ☐ Other date	

If COBRA, indicate number of months eligible for coverage: ☐ 18 months ☐ 29 months ☐ 36 months

If State Continuation (COC), eligible period of coverage cannot exceed 3 months.

2. EMPLOYEE INFORMATION (employee to complete sections 2 through 4)

Employee name (Last)	(First)	(MI)	☐ Married ☐ Unmarried	Daytime phone	E-mail address (Required)

Home address	City	State	ZIP	Mailing address (if different than home address)	City	State	ZIP

3. ENROLLMENT INFORMATION

Plan choice
Heritage Plus 1

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 card names are limited to 26 characters and spaces.

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

Does a dependent have a different mailing address? ☐ No ☐ Yes, complete the following: Dependent's Name (Last, First, MI) _____

Dependent's mailing address _____ City _____ State _____ ZIP _____

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

Will any applicant have other current health coverage including Medicare or Premera, which will remain in effect when your Premera coverage begins?
☐ No ☐ Yes, please complete and attach the *Other Coverage Questionnaire* form.

4. EMPLOYEE SIGNATURE

In applying for enrollment as indicated on this application, 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.

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.

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; 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 (including your spouse) 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 30 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 30 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 and does not qualify as a Special Enrollee. If you or your dependents are Late Enrollees, you or your dependents may enroll during the next occurring Annual Group Enrollment Period.

CREDITABLE COVERAGE

“Creditable Coverage” means prior or ongoing healthcare coverage including any group healthcare coverage (including the Federal Employees Health Benefits Plan and the Peace Corps), individual healthcare coverage (including student health plans), Medicare, Medicaid, CHAMPUS, Indian Health Service or tribal organization coverage, state high-risk pool coverage, state Children’s Health Insurance Programs (CHIP), a public health plan established or maintained by a State, the U.S. government, a foreign country, or any political subdivision of a State, the U.S. government, or a foreign country that provides health coverage to individuals who are enrolled in the plan.

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