

Employer Name LEOFF HEALTH & WELFARE TRUST			Dept. #	Social Security Number		Effective Date
Employee Name (Last)		(First)	(MI)	Home Phone		Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married
				Work Phone		
Home Address (Street and Number)		City	County	State	Zip Code	Date of Hire
						Date of Rehire

Please check appropriate box and provide date

New Employee Open Enrollment

Employee Entered Eligible Class

Special Enrollment:

Marriage (date) _____ Birth (date) _____

Divorce (date) _____ Adoption (date of placement) _____

Death (date) _____ Dependent Change (date) _____

Involuntary Loss of Other Coverage (date) _____

For Internal Use Only:

Creditable Coverage Information. (Any preexisting condition limitation required by this program will be reduced by qualifying periods of creditable coverage.)

Do you or any dependent(s) applying for coverage have coverage with any health care plan now or in the 90-day period before your enrollment date? Yes No

Carrier Name and Phone Number _____ ID/Policy #: _____

Date coverage began: _____

Name of persons covered by other insurance: _____

Important Note: If you have additional prior coverage information, you may attach copies of Certificate of Health Coverage from your prior plan (s).

Is coverage still in effect? Yes No If yes, will coverage still be in effect when this coverage begins? Yes No If no, date coverage ended or will end: _____

If the dependent child(ren) being added is/are covered under another plan and the natural parents are divorced or separated, please provide:

- Name of parent with custody (if parents have dual custody, indicate): _____
- If divorced, did the court establish financial responsibility for the child(ren)'s health care? Yes No If yes, please specify the name and address of parent with responsibility: _____

Enrollment										
Add	Drop	Relationship to Employee	Name (Last, First, Middle Initial)	Social Security Number	Sex M/F	Birthdate Mo/Day/Year	Are you or your spouse Medicare Eligible?	Disabled	IRS Tax Deduction?	Type of Coverage
<input type="checkbox"/>	<input type="checkbox"/>	Self						N/A	N/A	<input type="checkbox"/> Medical <input type="checkbox"/> Vision
<input type="checkbox"/>	<input type="checkbox"/>	Spouse						N/A	N/A	<input type="checkbox"/> Medical <input type="checkbox"/> Vision
<input type="checkbox"/>	<input type="checkbox"/>	Child								<input type="checkbox"/> Medical <input type="checkbox"/> Vision
<input type="checkbox"/>	<input type="checkbox"/>	Child								<input type="checkbox"/> Medical <input type="checkbox"/> Vision
<input type="checkbox"/>	<input type="checkbox"/>	Child								<input type="checkbox"/> Medical <input type="checkbox"/> Vision
<input type="checkbox"/>	<input type="checkbox"/>	Child								<input type="checkbox"/> Medical <input type="checkbox"/> Vision

I hereby verify that all of the information specified above is accurate and complete. I have also read and understand the information on the reverse side. I authorize 1) the release of any medical records needed for accurate claims processing; 2) the release of information deemed necessary under the Plan to correctly coordinate benefits with another Plan or insurance carrier, and 3) the payment of benefits directly to a provider of medical care at the option of the Plan.

I am waiving coverage under the Plan for myself and my dependents for my dependents only I/we have other coverage Yes No

Employee Signature

Date Signed