

Employee: Please complete all sections (front & back) in black ink

# MBA Group Insurance Trust Employee / Subscriber Application

Select Plan: Health plans underwritten by Regence BlueShield:  Preferred Plan \_\_\_\_\_  HSA Plan \_\_\_\_\_  Point-of-Service (Selections) \_\_\_\_\_  
Health plans underwritten by Group Health Options, Inc.:  Options Plan \_\_\_\_\_

## EMPLOYEE SECTION:

Employee Legal Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone #: \_\_\_\_\_

Marital Status:  Married  Single Date of Marriage: \_\_\_\_\_

Have Regence BlueShield or Group Health Options, Inc. assigned an alternate Identification number to you previously?  Yes  No If yes, please provide if available: \_\_\_\_\_

Please Note: List all eligible dependents to be insured

### A Reason Must be Checked for Application:

#### Add Employee:

- New group
- New employee
- Open enrollment
- Loss of eligibility on another coverage

#### Add Dependent:

- Birth  Marriage  Adoption  COBRA coverage exhausted
- Open enrollment
- Loss of eligibility on another coverage
- Add DP (domestic partner) and dependent(s)  
(If employer allows DP coverage) (Must attach DP affidavit)
- Add dependent(s) only, of DP (domestic partner)  
(If employer allows DP coverage) (Must attach DP affidavit)

- Personal Care Provider change
- Change of Life Beneficiary
- Change of Address
- Name Change
- Change Medical Plan \*

\* Plan election changes are allowed only during the Open Enrollment Period (October 1<sup>st</sup> of each year)

Relationship	Name			Social Security Number or Individual tax payor ID number (ITIN)	Birth Date (mm/dd/yyyy)	Gender M/F	Personal Care Provider for Point of Service Plan only (First & Last Name)	PCP Rider #	Current Patient Y/N
	Last Name	First Name	M.I.						
Employee				- -	/ /				
Spouse				- -	/ /				
Child				- -	/ /				
Child				- -	/ /				
Child				- -	/ /				

If any dependent child(ren) being added is/are covered under another plan and the natural parents are divorced or separated, Washington State regulations require that we ask the following:

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 (Please provide a copy of the divorce decree maintenance agreement outlining coverage specifications.)

If YES, please specify the name and address of the parent with responsibility: \_\_\_\_\_

Do you or any of your dependents applying for coverage have coverage (now, or within the past 6 months) with any health care plan?  Yes  No. Will coverage remain in effect?  Yes  No

IMPORTANT: If you or any of your dependents applying for coverage have coverage (now, or within the past 6 months) with any health care plan, you MUST complete the back of this form.

Completing the information on the back of this form will allow Regence BlueShield or Group Health Options, Inc. to credit any applicable waiting periods for preexisting conditions and process claims quickly and accurately.

**BASIC LIFE INSURANCE BENEFICIARY:** This section must be completed for all new employee enrollments. If no beneficiary is designated, benefits will be paid under the terms of the group insurance contract.

Beneficiary's Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Beneficiary's Birthdate: \_\_\_\_\_ Provided by: Regence Life & Health Insurance Company

Beneficiary's Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_ Phone Number: \_\_\_\_\_ PO Box 1271, Portland, OR 97207

**EMPLOYEE RELEASE AND AUTHORIZATION:** I hereby verify that all of the information specified above is accurate and complete. By signing below, I have authorized the release of information, for myself and my dependents listed above, to Regence BlueShield or Group Health Options, Inc.

EMPLOYEE'S SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

**EMPLOYER SECTION:** The Employer section must be completed & signed by the Group's Contact Person as listed on the Employer Participation Agreement. If not fully completed, this form will be returned unprocessed.

Group Name: \_\_\_\_\_ Group Number: \_\_\_\_\_ Division Number: \_\_\_\_\_ Group Phone Number: \_\_\_\_\_ Intended Effective Date: \_\_\_\_\_

Employee Class (i.e. Hourly or Salaried): \_\_\_\_\_ Date of Hire: \_\_\_/\_\_\_/\_\_\_ Date of Rehire: \_\_\_/\_\_\_/\_\_\_ Date Changed from Part-time to Full-time: \_\_\_\_\_ Average Hours Worked Per Week: \_\_\_\_\_

**SIGNATURE OF GROUP'S PRIMARY CONTACT PERSON:** \_\_\_\_\_ Date: \_\_\_\_\_

**This Section for Carrier Use Only – RIQ Code:** \_\_\_\_\_ Rel ICN#: \_\_\_\_\_ Eff Date: \_\_\_\_\_  
ACRW Loaded: \_\_\_\_\_ COB Loaded: \_\_\_\_\_ Date Completed: \_\_\_\_\_ Auditor Initials: \_\_\_\_\_ Plan Code: \_\_\_\_\_

## Employee Section:

## MBA Group Insurance Trust Employee / Subscriber Application

Crediting of time covered under a previous insurance plan towards a new plan's pre-existing condition waiting period (i.e. Portability of coverage) is available under the MBA Trust in accordance with State and Federal insurance regulations. All MBA plans include a 3-month waiting period for Pre-Existing Conditions. In addition, all plans include a 6-month waiting period for transplant related benefits. Portability of Coverage does not apply towards the Transplant waiting period. In order for our carriers to determine if you or any of your dependents are eligible for portability of coverage in accordance with State and Federal laws, please provide a "Certificate of Creditable Coverage" from your prior health insurance carrier; or, complete the "Prior Coverage Information" section below. To obtain more information on waiting periods, pre-existing conditions and transplant related benefits, please contact your group administrator or benefits department.

### PRIOR INSURANCE WITHIN THE PAST 6 MONTHS AND/OR CURRENT OTHER INSURANCE COVERAGE:

Prior or Other Insurance Company Name: \_\_\_\_\_ Prior or Other Insurance Company Phone #: \_\_\_\_\_

Prior or Other Insurance Company Full Address: \_\_\_\_\_

Policyholder's Name: \_\_\_\_\_ Policyholder's Birth Date: \_\_\_/\_\_\_/\_\_\_ (mm/dd/yyyy) Policy Holder's Member ID# or Social Security #: \_\_\_\_\_

Group Name & Policy #: \_\_\_\_\_ Effective Date of Coverage: \_\_\_/\_\_\_/\_\_\_ Intended Termination Date of Coverage: \_\_\_/\_\_\_/\_\_\_ Reason for Termination: \_\_\_\_\_

Persons covered by prior insurance (list names and date of birth for each): \_\_\_\_\_

**Type of Coverage (please circle):** Medical Pharmacy Dental Vision Medicare      **Type of Policy (please circle):** Group Individual Medicaid Medicare Part A Medicare Part B Other: \_\_\_\_\_

If employee or dependents have Medicare, what was the begin date for Part A: \_\_\_\_\_ Part B: \_\_\_\_\_ Medicare HIC# with Alpha Suffix: \_\_\_\_\_

Name of Person covered by Medicare \_\_\_\_\_ Reason:  Disability  Over Age 65  End Stage Renal Disease

**Contractual Effective Date and Eligibility:** Applications for new employees must be received by the MBA Trust within 15 days of the Contractual Effective Date. The Contractual Effective Date is based on the employee's date of hire and your company's established probationary period. Applications received after the Contractual Effective Date may delay an employee's eligibility date to the next MBA Trust Open Enrollment period (Oct 1<sup>st</sup> of each year). New MBA application forms are required to add dependents, including newborns and/or a new spouse (see Plan Booklets for details). Applicants should carefully review the program's "Waiting Periods Limitations" and "Listed" conditions. Review the plan benefit booklets or contact your company's administrator (or the MBA Trust) to address any questions on these important provisions.

**Eligible Dependents may include:** A subscriber's legal spouse; a natural, adopted or stepchild provided that the child is: 1) unmarried; and 2) under the age of 25 (Incapacitated Children over Age 25). Application for newborn children must be received within 60 days of birth (newborn's social security number is not required to make application). Application to add a new spouse must be received within 31 days of the date of marriage. See benefit booklets for details regarding dependent eligibility.

**HIPAA Special Enrollment Provisions:** If you decline enrollment for yourself or your dependents (including your spouse) due to coverage through other health coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you submit a completed "Waiver of Insurance Form" within 30 days of your initial eligibility for this plan **and** you request enrollment within 30 days after your coverage ends. To qualify for this special enrollment, you or your dependents must have lost health insurance or other group health coverage because: 1) the health insurance was provided under COBRA, and the COBRA period was exhausted **-OR-** 2) the coverage was non-COBRA coverage and the coverage terminated due to loss of eligibility for coverage (including loss resulting from legal separation, divorce, death, termination of employment, or reduction in hours), **-OR-** 3) the coverage was non-COBRA coverage and employer contributions for the coverage were terminated. Under this provision, an employer's reduction (but not cessation) of contributions would **not** trigger a special enrollment right. In addition, if you require a new dependent as a result of marriage, birth, adoption or placement for adoption, you may also be able to enroll yourself and your dependents provided you request enrollment within 31 days after the marriage, and within 60 days after birth, adoption or placement for adoption if additional premium is required.

**Application Agreement:** I have provided these answers as part of the application procedure required by the issuer to enroll in coverage and I certify that all information completed on this form is true, correct and complete. I understand that the the issuer will rely on each answer in making coverage and rating determinations. If the issuer continues the Contract with the Group after untrue, incorrect, or incomplete information is found to have been provided, and if as a result of correcting false information the Group no longer qualifies for the Rate quoted, I understand that the issuer will have the right to adjust the rates to the appropriate level retroactive to the date the misrepresentation occurred, and the Group will be required to pay the Rate adjustment within 30 days of the date of notice by the issuer. For the protection of all of our members, fraud or misrepresentation of material fact by me and/or the Group for purposes of defrauding the issuer, may result in the issuer taking any action allowed by law or contract, including termination or rescission of coverage, denial of benefits, and/or pursuit of criminal charges and penalties. In addition, the issuer will have the right to collect any claims payments or other damages.

**Release of Information:** I acknowledge and understand my health plan may request or disclose health information about me or my dependents (persons who are eligible for benefits coverage and are listed on the enrollment form) for the purpose of facilitating health-care treatment, payment or for the purpose of business operations necessary to administer health-care benefits; or as required by law\*. Health information requested or disclosed may be related to treatment or services performed by: a physician, dentist, pharmacist or other physical or behavioral health care practitioner; a clinic, hospital, long term care or other medical facility; any other institution providing care, treatment, consultation, pharmaceuticals or supplies; or an insurance carrier or group health plan. Health information requested or disclosed may include, but is not limited to: claims records, correspondence, medical records, billing statements, diagnostic imaging reports, dental records, or hospital records (including nursing records and progress notes). This acknowledgement does not apply to obtaining information regarding psychotherapy notes. A separate authorization will be used for psychotherapy notes.

\* For more information about such uses and disclosures, including uses and disclosures required by law, please refer to the Notice of Privacy Practices. A copy is available from our Website at [www.epkbenefits.com](http://www.epkbenefits.com) or by phone at (800) 545-7011 or (425) 641-7762.

Coverage Provided by: Regence BlueShield  
PO Box 21267 -- Seattle, WA 98111-3267

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320 Westlake Ave N #100 -- Seattle, WA 98109-5218