NMTA Voluntary Employee Enrollment & Change Form

Please complete and return forms to:

EPK & Associates, Inc. - 15375 SE 30th Place, Suite 380 - Bellevue, WA 98007

Employer Section

Employer Name	**Group Number**	**Div. Number**
Employee ID Number (EPK to complete)	**Employee Class**	

☐ Open Enrollment ☐ New Enrollment ☐ Change of Existing Enrollment – Please indicate reason for change below

Date of Hire _____ **or** Date of Rehire _____ **or** Date Changed from Part-time to Full-time _____

Was employee subject to an Orientation Period? ☐ Yes ☐ No

Was employee subject to a Measurement Period? ☐ Yes ☐ No

If yes, date employee satisfied eligibility requirements: _____

Employee's Name (Last, First, MI)	☐ Male ☐ Female	Date of Birth	
Social Security Number	☐ Married ☐ Single	Phone Number	Effective Date
Mailing Address	City	State	Zip

Spouse/Dependents to be enrolled: A Spouse is defined as your legal husband or wife or your Domestic Partner. Dependent children must be under 26 years of age. Please contact your employer for any additional eligibility requirements.

Name (Last, First, MI)	Social Security Number	Date of Birth	Sex	Relationship (Spouse/DP, Child)
			☐ Male ☐ Female	
			☐ Male ☐ Female	
			☐ Male ☐ Female	
			☐ Male ☐ Female	

List names as they should appear on your identification card. If enrolling additional dependents, please attach a separate sheet including the information above.

If changing existing enrollment, indicate reason below:

☐ **Name Change** – Former name _____ ☐ **Address Change**

Add Employee or Dependent

Reason for Application: ☐ Marriage / Domestic Partnership – Date _____

☐ Newborn – Date of Birth _____ ☐ Adoption – Date of Placement in Home _____

☐ Loss of Coverage – Termination Date _____ Reason _____

Name of Prior Carrier _____ Phone Number _____

Prior Policy Number _____ Identification Number _____

Coverage was ☐ Group ☐ Individual ☐ Medical ☐ Dental ☐ Vision

Coverage was for ☐ Self ☐ Spouse ☐ Child(ren) ☐ Family as listed above (check all that apply)

Dental Coverage Underwritten by:
Delta Dental of Washington
400 Fairview Avenue N., Suite 800
Seattle, WA 98109

Vision Underwritten by:
LifeMap Assurance Company
100 SW Market St
Portland, OR 97201

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Other or Prior Coverage Information: This is not a waiver of coverage. This information is required for payment of claims.

Do you or any family members enrolling have other Dental coverage? ☐ Yes ☐ No

Do you or any family members enrolling have other Vision coverage? ☐ Yes ☐ No

If yes, provide the information regarding other coverage requested.

Name of Family Member with other coverage		Relationship
Name of Insurance Carrier		Carrier Phone Number ( )
Complete Address of Other Carrier		Effective Date of Coverage
Policy Number	ID Number	Termination Date (if applicable)
This plan covers (check all that apply) ☐ Self ☐ Spouse ☐ Child(ren) ☐ Family as listed above		
Is the coverage of any dependent affected by a divorce decree/court order? ☐ Yes ☐ No If yes, please include the portion of decree that shows responsibility for health expenses.		

I hereby apply for enrollment with Delta Dental of Washington and/or LifeMap Assurance Company under the Group Dental and/or Vision Insurance Policy of the Employer named on Page 1. I hereby authorize the Employer named on Page 1 to withhold insurance premiums, if required, from my paycheck and to pay them directly to the applicable carriers. I acknowledge and understand that Delta Dental of Washington and/or LifeMap Assurance Company may request or disclose health information about me or my dependents (persons who are listed for benefits coverage on the enrollment form) from time to time for purposes of facilitating health care treatment; payment 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, ophthalmologist, 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
- and insurance carrier or group health plan.

Health information requested or disclosed may include, but is not limited to: claims records, correspondence, medical records, billing statement, diagnostic imaging reports, laboratory reports, dental records, or hospital records (including nursing records or progress reports).

Insurance Fraud Warning:

Any person who knowingly provides false, incomplete, or misleading information to an insurance company for the purpose of defrauding the insurance company may be guilty of a crime. Penalties may include imprisonment, fines, and denial of insurance benefits. I represent that each of the above statements and answers are complete and true to the best of my knowledge and belief. I understand that if I have made intentionally false or misleading statements or answers on behalf of myself or any family members that all coverage under this Policy will terminate for such Member retroactively to the Effective Date.

_____ _____

Employee's Full Name (please print clearly) Employee's Signature

_____

Date Signed

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