BIAW Health Insurance Trust

Employee / Subscriber Application

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

Select Plan

Plans underwritten by Regence BlueShield :

❑ Market Plan _____ ❑ Market "Plus" Plan _____ ❑ Foundation Plan _____

❑ Foundation "Plus" Plan _____ ❑ HSA Plan _____ ❑ Traditional Plan _____

Plans underwritten by Kaiser Foundation Health Plan of Washington Options, Inc:

❑ Access PPO Plan _____ ❑ HSA Plan _____

Plans underwritten by Kaiser Foundation Health Plan of Washington:

❑ HMO Plan _____ ❑ HMO HSA Plan _____

EMPLOYEE SECTION:

Employee Social Security Number: _____

First Name: _____ Middle Initial: _____ Last Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone #: _____ Email: _____

Date of Birth (MM/DD/YYYY): _____ Gender: ❑ Male ❑ Female

Marital Status: ❑ Married ❑ Single Date of Marriage: _____

A Reason Must be Checked for Application:

Add Employee

❑ New Group
❑ New Employee
❑ Open Enrollment
❑ Loss of Eligibility on Another Coverage
❑ Change of Life Beneficiary
❑ Change of Address
❑ Name Change
❑ Change Medical Plan*

Add Dependent

❑ Birth ❑ Marriage ❑ Adoption
❑ Domestic Partner
❑ COBRA coverage exhausted
❑ Open enrollment
❑ Loss of eligibility on another coverage (must attach proper documentation)

*** Medical Plan election changes are allowed only during the Open Enrollment Period each year or with a HiPPA qualifying event.**

Contractual Effective Date and Eligibility: Applications for new employees must be received by the BIAW Trust within 10 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 BIAW Trust Open Enrollment period. New BIAW application forms are required to add dependents, including newborns and/or a new spouse (see Plan Booklets for details).

Relationship	**Last Name**	**First Name**	**M.I.**	**Social Security Number** or Individual tax payer ID number (ITIN)	**Birth Date** (mm/dd/yyyy)	**Gender** M/F
Spouse/Domestic Partner					/ /	
Child					/ /	
Child					/ /	
Child					/ /	

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. Please contact EPK & Associates for an additional form if you would like to designate a Contingent Beneficiary.

Coverage Underwritten by LifeMap Assurance Company 100 SW Market Street, Portland, OR 97201

Primary Beneficiary's Name: _____ Relationship: _____ Beneficiary's Birthdate: _____ Percentage of Benefit: _____

Primary Beneficiary's Address: _____ City/State/Zip: _____ Phone Number: _____

Primary Beneficiary's Name: _____ Relationship: _____ Beneficiary's Birthdate: _____ Percentage of Benefit: _____

Primary Beneficiary's Address: _____ City/State/Zip: _____ Phone Number: _____

EMPLOYEE RELEASE AND AUTHORIZATION: I hereby verify that all of the information specified above is accurate and complete and acknowledge that I have read and understand all information on the second page of this application. By signing below, I have authorized the release of information, for myself and my dependents listed on this application, to Regence BlueShield, Kaiser Foundation Health Plan of Washington Options, Inc., Kaiser Foundation Health Plan of Washington, Delta Dental of Washington and/or LifeMap Assurance Company. **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: ❑Class 1 ❑Class 2 ❑Class 3 ❑Class 4 Date of Hire: _____/____/____ Date of Rehire: _____/____/____ Date Changed from Part-time to Full-time: _____/____/____ Average Hours Per Week:_____

Was employee subject to an Orientation Period as selected on the Employer Participation Agreement? ❑Yes ❑No Was employee subject to a Measurement Period as selected on the Employer Participation Agreement? ❑Yes ❑No

If yes, date employee satisfied eligibility requirements: _____/_____/_____

SIGNATURE OF GROUP'S PRIMARY CONTACT PERSON: _____ **Date**: _____

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 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 with any health care plan, you MUST complete the information below.

OTHER CURRENT OR PRIOR INSURANCE COVERAGE:

Other Insurance Company Name:_____ Other Insurance Company Phone #:_____

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: ❑ Medical ❑ Pharmacy ❑ Dental ❑Vision ❑ Medicare **Type of Policy**: ❑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

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Application Agreement: I have provided these answers as part of the application procedure required by Regence BlueShield, Kaiser Foundation Health Plan of Washington Options, Inc., Kaiser Foundation Health Plan of Washington, Delta Dental of Washington and/or LifeMap Assurance Company to enroll in coverage and I certify that all information completed on this form is true, correct and complete. I understand that Regence BlueShield, Kaiser Foundation Health Plan of Washington Options, Inc., Kaiser Foundation Health Plan of Washington, Delta Dental of Washington and/or LifeMap Assurance Company will rely on each answer in making coverage and rating determinations. 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.

HIPAA Special Enrollment Provisions: If I have waived enrollment and completed a "Waiver of Insurance Form" for myself or any of my dependents (including my spouse) because of other health insurance or group health plan coverage, I may in the future be able to enroll the waived individuals in this plan, provided I request enrollment within 30 days after the other coverage of the individual(s) ends due to loss of eligibility or an employer's ceasing to contribute toward that other coverage. In addition, if I have a new dependent as a result of marriage, birth, adoption, or placement for adoption, I may be able to enroll myself and my dependents, provided that I request enrollment within 30 days after the marriage, or within 60 days after the birth, adoption, or placement.

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, laboratory 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 or by phone at (800) 545-7011 or (425) 641-7762.

Coverage underwritten by: **Regence BlueShield**
1800 Ninth Avenue -- Seattle, WA 98101
Kaiser Foundation Health Plan of Washington Options, Inc. and Kaiser Foundation Health Plan of Washington
601 Union St, Suite 3100, Seattle, WA 98101
P.O. Box 34750, Seattle, WA 98124-9745
Delta Dental of Washington
400 Fairview Ave N., Suite 800, Seattle, WA 98109
LifeMap Assurance Company
100 SW Market Street, Portland, OR 97201
First Choice Employee Assistance Program
600 University St, Suite 1400, Seattle, WA 98101

Mail or Fax to:
EPK & Associates, Inc. - 15375 SE 30th Place #380 - Bellevue, WA 98007
Phone: 800-545-7011 - Fax 425-641-8114

BIAW Health Insurance Trust
Employee / Subscriber Application

Please use this page, if necessary, to enroll additional dependents.

EMPLOYEE SECTION:

Employee Social Security Number: _____

First Name: _____ Middle Initial: _____ Last Name: _____

Addtional Dependents Continued from First Page

Relationship	**Last Name**	**First Name**	**M.I.**	**Social Security Number** or Individual tax payer ID number (ITIN)	**Birth Date** (mm/dd/yyyy)	**Gender** M/F
Child					/ /	
Child					/ /	
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Russian: В данном Уведомлении содержится важная информация. Asuris несет обязательства по соблюдению применимых норм федерального законодательства о гражданских правах и не допускает дискриминации по признаку расы, цвета кожи, национального происхождения, возраста, статуса инвалидности или пола. В данном уведомлении содержится важная информация о вашем заявлении или страховом покрытии. Обратите внимание на ключевые даты, указанные в данном уведомлении. Возможно, вам нужно предпринять некоторые действия к определенному сроку, чтоб сохранить страховое покрытие или получить помощь с расходами. Вы имеете право получить данную, а также прочую информацию о вашем заявлении или страховом покрытии на родном языке бесплатно. Позвоните по номеру 888-232-8229. (TTY: 711)

Tagalog: Ang Abiso na ito ay may Mahalagang Impormasyon. Ang Asuris ay sumusunod sa mga naaangkop na Pederal na batas sa mga karapatang sibil at hindi nagdidiskrimina batay sa lahi, kulay, bansang pinagmulan, edad, kapansanan, o kasarian. Ang abiso na ito ay may mahalagang impormasyon tungkol sa iyong aplikasyon o coverage. Hanapin ang mga importanteng petsa sa abiso na ito. Maaaring kailangan mong gumawa ng hakbang hanggang sa mga partikular na takdang araw upang mapanatili mo ang iyong coverage sa kalusugan o tulong sa mga gastusin. May karapatan kang makuha ang impormasyong ito, at iba pang impormasyon tungkol sa iyong aplikasyon o coverage, sa iyong sariling wika nang walang bayad. Tumawag sa 888-232-8229. (TTY: 711)

Ukrainian: Це повідомлення містить важливу інформацію. Asuris дотримується застосовного федерального законодавства про громадянські права та не проводить політику дискримінації за расовою приналежністю, кольором шкіри, походженням, віком, інвалідністю та статевою ознакою. Це повідомлення містить важливу інформацію про пов’язану з вами програму або страхове покриття. Зверніть увагу на ключові дати в цьому повідомленні. Щоб зберегти за собою план медичного страхування або право отримувати грошову допомогу, можливо, вам потрібно буде вжити відповідні заходи, для яких установлено певні часові обмеження. Ви маєте право на безкоштовне отримання рідною мовою як цієї інформації, так і будь-якої іншої, пов’язаної з програмою чи страховим покриттям. Телефонуйте за таким номером: 888-232-8229 (телетайп: 711).

Mon-Khmer, Cambodian: សេចក្តីជូនដំណឹងនេះមានព័ត៌មានសំខាន់ ។ Asuris
អនុលោមទៅតាមច្បាប់របស់សហព័ន្ធស៊ីពីសិទ្ធិពលរដ្ឋ ហើយមិនមានការរើសអើងចំពោះពូជសាសន៍ ពណ៌សម្បរ
សញ្ជាតិដើម អាយុ ពិការភាព ឬភេទឡើយ ។ សេចក្តីជូនដំណឹងនេះមានព័ត៌មានសំខាន់ស្តីអំពីពាក្យសុំ
ឬការធានារ៉ាប់រងសុខភាពរបស់អ្នក ។ សូមរកមើលកាលបរិច្ឆេទសំខាន់ៗក្នុងសេចក្តី ជូនដំណឹងនេះ ។
អ្នកអាចត្រូវចាត់វិធានការឲ្យបានត្រឹមកាលបរិច្ឆេទកំណត់ ដើម្បីរក្សាបាននូវការធានារ៉ាប់រងសុខភាព
ឬបានទទួលការជួយចេញការចំណាយថ្លៃថែទាំសុខភាពរបស់អ្នក ។ អ្នកមានសិទ្ធិទទួលបានព័ត៌មាននេះ
និងព័ត៌មានដទៃ អំពីពាក្យសុំ ឬការធានារ៉ាប់រងសុខភាពរបស់អ្នក ជាភាសាដែលអ្នកប្រើ
ដោយមិនបាច់បង់ប្រាក់ឡើយ ។ ហៅមកលេខ 888-232-8229 ។ (អ្នកពិបាកស្តាប់ ឬពិបាកនិយាយដែលប្រើ TTY
សូមហៅមកលេខ ៖ 711)

Japanese: このお知らせには大変重要な情報が含まれています。Asuris は、適用される連邦公民権法を遵守し、人種、肌の色、出身国、年齢、身体障害、性別による差別をしません。このお知らせには保険の申請と適用に関する重要な情報が含まれています。このお知らせに記載されている重要な日付にご注意ください。健康保険適用や医療費支援を引き続き受けるためには締切日までに手続きを行う必要があります。あなたにはこのお知らせおよび申請と保険適用に関するその他の情報について、無料かつ母国語で知る権利があります。こちらまでお電話ください: 888-232-8229。(TTY: 711)

Amharic: ይህ ማሳሰቢያ ጠቃሚ መረጃ ይዟል።። Asuris በሚተገበረው የፌደራል ሲቪል መብቶች ህግጋት በዘር፣ በቀለም፣ በመጡበት ብሄር፣ እድሜ፣ የአካል ጉዳት ወይም ፆታ መድሎ አይደረግም።። ማሳሰቢያው ስለ ማመልከቻዎትና ሽፋን ጠቃሚ መረጃ አለው።። በዚህ ማሳሳቢያ ላይ ቁልፍ ቀናትን ይፈልጉ።። በተወሰኑ የመጨረሻ ቀናት የጤና ሽፋኑ ላይ ወይም የወጪን ድጋፍ እንዲቀጥል እረምጃ መውሰድ ያስፈልጋል።። ይህንን መረጃ እንዲሁም በማመልከቻዎት ወይም ሽፋኑ ላይ ሌሎችንም መረጃዎች በራስዎን ቋንቋ ያለምንም ክፍያ የማግኘት መብት አሎት።። 888-232-8229 ይደውሉ።። (ቲቲዋይ፡- 711)

Cushite/Oromo: Beeksisni kun odeeffannoo barbaachisaa qabatee jira. Asuris Ulaagaa seera mirga Siivilii Federaalaa kan guutuu fi sanyii, bifa, lammummaa, umrii, miidhama qaamaa ykn saala irratti hundaa’ee addaan hinqoodne dha. Beeksisni kun iyyannoo ykn haguuggii kara keessan irratti odeeffannoo barbaachisaa qabatee jira. Guyyoota furtuu beeksisa kana keessa jiran ilaalaa. Haguuggii fayyaa ykn gargaarsa keessan eeggachuuf hanga dhuma yeroo ta’eetti tarkanfii ta’e gatii bastanii fudhachuu qabdu. Odeeffannoo kana fi waa’ee iyyannoo ykn haguuggii keessanii kaffaltii tokko malee afaan keessaniin argachuuf mirga qabdu. Bilbilaa 888-232-8229. (TTY: 711)

Arabic:

يحتوي هذا الإخطار على معلومات مهمة. تمتثل Asuris إلى قوانين الحقوق المدنية الفيدرالية المعمول بها ولا تمارس التمييز على أساس العرق أو اللون أو الأصل القومي أو السن أو الإعاقة أو الجنس. يحتوي هذا الإخطار على معلومات مهمة عن الطلب أو التغطية الخاصة بك. ابحث عن التواريخ الرئيسية في هذا الإخطار. فقد تحتاج إلى اتخاذ إجراء ما قبل بعض المواعيد النهائية للحفاظ على التغطية الصحية الخاصة بك أو تلقي مساعدة بخصوص التكاليف. لديك الحق في الحصول على هذه المعلومات والمعلومات الأخرى المتعلقة بالطلب أو التغطية الخاصة بك بلغتك مجانًا. اتصل بالرقم 888-232-8229. (الكتابة عن بُعد للصم: 711)

Punjabi: ਇਸ ਨੋਟਿਸ ਵਿੱਚ ਮਹੱਤਵਪੂਰਨ ਜਾਣਕਾਰੀ ਹੈ। Asuris ਲਾਗੂ ਫੈਡਰਲ ਨਾਗਰਿਕ ਅਧਿਕਾਰਾਂ ਦੇ ਕਨੂੰਨ ਦੇ ਅਨੁਰੂਪ ਹੈ ਅਤੇ ਜਾਤਿ, ਰੰਗ, ਰਾਸ਼ਟਰੀ ਮੂਲ, ਉਮਰ, ਅਪਾਹਿਜਤਾ, ਜਾਂ ਲਿੰਗ ਦੇ ਅਧਾਰ 'ਤੇ ਭੇਦਭਾਵ ਨਹੀਂ ਕਰਦਾ। ਇਸ ਨੋਟਿਸ ਵਿੱਚ ਤੁਹਾਡੇ ਬੇਨਤੀ-ਪੱਤਰ ਅਤੇ ਸੁਰੱਖਿਆ ਬਾਰੇ ਮਹੱਤਵਪੂਰਨ ਜਾਣਕਾਰੀ ਹੈ। ਇਸ ਨੋਟਿਸ ਵਿੱਚ ਮੁੱਖ ਮਿਤੀਆਂ ਵੇਖੋ। ਤੁਹਾਨੂੰ ਤੁਹਾਡੀ ਸਿਹਤ ਸੁਰੱਖਿਆ ਰੱਖਣ ਜਾਂ ਲਾਗਤਾਂ ਨਾਲ ਮਦਦ ਕਰਨ ਲਈ ਨਿਯਤ ਮਿਆਦ ਸੀਮਾਵਾਂ ਦੁਆਰਾ ਕਾਰਵਾਈ ਕਰਨ ਦੀ ਲੋੜ ਹੋ ਸਕਦੀ ਹੈ। ਤੁਹਾਨੂੰ ਇਹ ਜਾਣਕਾਰੀ, ਅਤੇ ਆਪਣੇ ਬੇਨਤੀ ਪੱਤਰ ਜਾਂ ਸੁਰੱਖਿਆ ਬਾਰੇ ਹੋਰ ਜਾਣਕਾਰੀ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਬਿਨਾ ਕਿਸੇ ਲਾਗਤ ਤੋਂ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੈ। 888-232-8229 'ਤੇ ਕਾਲ ਕਰੋ। (TTY: 711)

German: Diese Mitteilung enthält wichtige Informationen. Asuris hält die Grundrechte der USA ein und es finden keine Diskriminierungen aufgrund von Rasse, Hautfarbe, nationaler Herkunft, Alter, Behinderung oder Geschlecht statt. Diese Mitteilung enthält wichtige Informationen über Ihren Antrag oder die entsprechende Versicherungsdeckung. Beachten Sie wichtige Fristen in dieser Mitteilung. Sie müssen unter Umständen Maßnahmen innerhalb bestimmter Fristen ergreifen, um Ihren Krankenversicherungsschutz zu erhalten oder eine Kostenerstattung zu erhalten. Sie haben das Recht, diese Informationen und andere Informationen über Ihren Antrag oder Ihren Versicherungsschutz kostenlos in Ihrer Sprache zu erhalten. Rufen Sie folgende Nummer an 888-232-8229. (Fernschreiber: 711)

Laotian: ແຈ້ງການສະບັບນີ້ ມີຂໍ້ມູນທີ່ສຳຄັນ. Asuris ສອດຄ່ອງກັບກົດໝາຍ ວ່າດ້ວຍ ສິດທິພົນລະເມືອງຂອງຣັຖບານກາງ ທີ່ກ່ຽວຂ້ອງ ແລະ ບໍ່ມີການຈຳແນກ ເຊື້ອຊາດ, ສີຜິວ, ຊາດກຳເນີດ, ອາຍຸ, ຄວາມເປັນຄົນພິການ ຫຼື ເພດ. ແຈ້ງການສະບັບນີ້ ມີຂໍ້ມູນທີ່ສຳຄັນກ່ຽວກັບການນຳໃຊ້ຂອງທ່ານ ຫຼື ການຄຸ້ມຄອງ. ຊອກຫາວັນທີທີ່ສຳຄັນໃນແຈ້ງການສະບັບນີ້. ທ່ານອາດຈະຕ້ອງການດຳເນີນການໃນຂອບເຂດເວລາໃດໜຶ່ງ ເພື່ອ ໃຫ້ສືບຕໍ່ໄດ້ຮັບການຄຸ້ມຄອງສຸຂະພາບຂອງທ່ານ ຫຼື ການຊ່ວຍເຫຼືອທາງດ້ານງົບປະມານ. ທ່ານມີສິດເອົາຂໍ້ມູນນີ້ ແລະ ຂໍ້ມູນອື່ນ ກ່ຽວກັບການສະໝັກ ຫຼື ການຄຸ້ມຄອງຂອງທ່ານ ທີ່ເປັນພາສາຂອງທ່ານໂດຍບໍ່ເສຍຄ່າໃຊ້ຈ່າຍ. ຕິດຕໍ່ 888-232-8229. (TTY: 711)