

## CITY OF RENTON

1055 South Grady Way Renton, WA 98057

**PLEASE PRINT CLEARLY**

**▶▶▶ EMPLOYER TO COMPLETE SHADED SECTION**

<b>Group Policy Numbers:</b> HEALTHCARE MANAGEMENT ADMINISTRATORS CITY OF RENTON #4034	<b>Employment Data:</b> Date of Hire: ____/____/____ Date of Rehire: ____/____/____ Effective Date: ____/____/____	Effective Date: ____/____/____ <input type="checkbox"/> Open Enrollment <input type="checkbox"/> New Employee <input type="checkbox"/> Re-instatement <input type="checkbox"/> Change in Status	<b>Change Form For:</b> <input type="checkbox"/> Reprint Cards <input type="checkbox"/> Name Change <input type="checkbox"/> Address Change Effective Date of Change: ____/____/____ <input type="checkbox"/> Add Dependent(s) <input type="checkbox"/> Drop Dependent(s) <input type="checkbox"/> Cancel Employee
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**▶▶▶ EMPLOYEE: PLEASE MAKE YOUR BENEFIT SELECTIONS HERE**

<b>LOCATION: <u>check one</u></b> <input type="checkbox"/> AFSCME <input type="checkbox"/> Non-Union/Mgmt <input type="checkbox"/> Non-union/clerical <input type="checkbox"/> Council/Mayor - elected <input type="checkbox"/> Police Guild – uniformed <input type="checkbox"/> Non-Uniform Police <input type="checkbox"/> Firefighters 864 <input type="checkbox"/> LEOFF I Active <input type="checkbox"/> LEOFF I Retired	<b>COVERAGE/PARTICIPANT ELECTIONS:</b> <input type="checkbox"/> EMPLOYEE <input type="checkbox"/> SPOUSE <input type="checkbox"/> DOMESTIC PARTNER* <input type="checkbox"/> CHILD(REN)	<b>MEDICAL/RX</b> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<b>DENTAL</b> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<b>VISION</b> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
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**▶▶▶ EMPLOYEE: PLEASE COMPLETE THIS INFORMATION ABOUT YOURSELF**

SOCIAL SECURITY NUMBER	LAST NAME	FIRST NAME	MI	DATE OF BIRTH	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	<input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED
HOME MAILING ADDRESS				HOME PHONE NUMBER	EMAIL ADDRESS	
CITY	STATE	ZIP		WORK PHONE NUMBER	JOB TITLE OR OCCUPATION	

**▶▶▶ EMPLOYEE: PLEASE COMPLETE THIS INFORMATION ABOUT DEPENDENTS WHO WILL BE ENROLLED ON MEDICAL/ DENTAL BENEFITS**

ADD	DROP	CHECK ALL THAT APPLY	LAST NAME, FIRST NAME	SOCIAL SECURITY NUMBER (REQUIRED FIELD)	DATE OF BIRTH	GENDER
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> SP / DP *				<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> CHILD				<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> CHILD				<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> CHILD				<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> CHILD				<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE

Are any of the dependent children listed above ELIGIBLE for coverage through their own employer's plan or through their spouse's employer's insurance plan?     Yes     No  
 If yes, please list the names of those dependents who are eligible for that coverage here: \_\_\_\_\_

\* If enrolling a Domestic Partner you will also need to submit an Affidavit of Domestic Partnership (available from Human Resources)

**▶▶▶ DISABLED DEPENDENT ELIGIBILITY**

List dependent who is developmentally disabled or physically handicapped who is over age 25:

Name: \_\_\_\_\_ Medical documentation must be submitted within 31 days of the effective date of coverage

**▶▶▶ EMPLOYEE: PLEASE COMPLETE THE FOLLOWING COORDINATION OF BENEFITS INFORMATION**

Currently do you, your spouse or any of your children have coverage through another insurance plan?  Yes  No

**If yes, please complete the following:**

Marital Status:  Single  Married  Widowed  Legally Separated  Divorced

Name of Spouse/Domestic Partner \_\_\_\_\_

If divorced, is there a court order for provision of the child?  Yes  No If Yes, please attach a copy of the court decree.

Per court decree: Who has custody of child? \_\_\_\_\_ Who provides insurance for child? \_\_\_\_\_

Please list the full name of the child(ren) \_\_\_\_\_

Please list both the natural parents name and date of birth:

Natural Father \_\_\_\_\_ / DOB \_\_\_\_\_ Natural Mother \_\_\_\_\_ / DOB \_\_\_\_\_

List all family member(s), including yourself, who are included on this enrollment form and are currently covered through another plan.

Name of covered members:	Type of Coverage: (M)edical (D)ental (V)ision	Type of Policy: (G)roup (I)ndividual	Effective date of coverage: ____/____/____	Carrier Name:
_____	_____	_____	____/____/____	_____
_____	_____	_____	____/____/____	_____
_____	_____	_____	____/____/____	_____

**Provide the following information on the carriers listed above:**

Carrier Name: \_\_\_\_\_ Policy Number: \_\_\_\_\_

Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Carrier phone #: \_\_\_\_\_ Subscriber's Name: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Date of birth: \_\_\_\_\_ Employer's Name and Address (if group coverage) \_\_\_\_\_

Is Employee, Spouse/Domestic Partner covered under this medical plan eligible for Medicare benefits?  Yes  No

If Yes, enter Date of Eligibility for Medicare Part A \_\_\_\_\_ Date of Eligibility for Medicare Part B \_\_\_\_\_ Social Security No. \_\_\_\_\_

**▶▶▶ RELEASE AND AUTHORIZATION**

I certify that the above listed information is correct and that I am enrolling only eligible dependents as defined in the Plan Document. *By signing this form, I attest that all dependent children listed for coverage are under age 26 and are not eligible for coverage through their own or their spouse's employer.* I understand that all entitlements to benefits are void, and coverage may be canceled or modified retroactively to its effective date, if I have made intentionally false or misleading statements or answers on behalf of myself or any family members. I authorize any person or institution providing care or services, or any organization in possession of insurance benefit information to release any and all information pertaining to the care or benefits provided to me or my dependents to Healthcare Management Administrators or its designated agent. I acknowledge and understand that my health plan 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 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: 1) A physician, dentist, pharmacist or other physical or behavioral health care practitioner; 2) A clinic, hospital, long term care or other medical facility; 3) Any other institution providing care, treatment, consultation, pharmaceuticals or supplies; or 4) 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 Privacy Notice. A copy is available upon request.

**PRINT EMPLOYEE NAME** \_\_\_\_\_ **▶▶▶ SIGNATURE** \_\_\_\_\_ **DATE** \_\_\_\_\_