

Member Enrollment & Change Form Health Alliance for Technology

Health Alliance for Technology, a Program under the Associated Employers Trust



1. Group Information (to be completed by the group)

Group Name: _____	Effective Date: _____ Date of Hire: _____	Rate of Pay and Amount: \$ _____ per <input type="checkbox"/> Yr <input type="checkbox"/> Month <input type="checkbox"/> Bi-Wk <input type="checkbox"/> Wk <input type="checkbox"/> Hr
<input type="checkbox"/> New <input type="checkbox"/> Change (Mark Reason Below) COBRA CARRY-OVER ELECTION MUST USE COBRA CARRYOVER APPLICATION TO ENROLL. <input type="checkbox"/> Hire/Rehire <input type="checkbox"/> Open Enrollment <input type="checkbox"/> Loss of Prior Coverage <input type="checkbox"/> Address/Name Change <input type="checkbox"/> Add or <input type="checkbox"/> Remove Dependent(s) Date: _____ Reason _____		
<input type="checkbox"/> Termination Last day Worked _____ Last day Compensated _____ Date Coverage Ends _____ <input type="checkbox"/> Voluntary Termination <input type="checkbox"/> Involuntary Termination <input type="checkbox"/> 3 Month Continuation of Coverage		

2. Employee Information (employee to complete sections 2 through 7)

Employee Name: (last, first, MI) _____	<input type="checkbox"/> Married <input type="checkbox"/> Unmarried	Social Security # - - - - -	Home Phone: () - - - -	Work Phone: () - - - -
Street Address: _____ City _____ State _____ Zip _____	Mailing Address (if different): _____ City _____ State _____ Zip _____			

3. Enrollment Information

I choose to **WAIVE** Medical/Rx coverage due to Medicare Supplement, but elect any ancillary coverage chosen by my employer (i.e. dental, vision). Basic Life not available.

I choose to **WAIVE** the Medical/Rx coverage for myself and my dependents. **Reason for Waiving:** _____

Medical Plan Choice *Underwritten by United HealthCare Insurance Company*
 I choose to **ELECT** medical coverage. Plan Selection _____ (Your employer has selected the options available to you. See your benefit administrator for details.)

Dental Plan Choice *Underwritten by United HealthCare Insurance Company*
 I choose to **ELECT** dental coverage. Plan Selection _____ (Your employer has selected the options available to you. See your benefit administrator for details.)

Vision Plan Choice *Underwritten by Vision Service Plan*
 I choose to **ELECT** vision coverage. Plan Selection _____ (Your employer has selected the options available to you. See your benefit administrator for details.)

Supplemental Employee and Dependent Life and AD&D *Underwritten by Unimerica Life Insurance Company (Only available if chosen by your employer)*
 Supplemental Employee Life/AD&D coverage. Yes No IF "YES" for Employee Coverage: Supp. Dependent Life/AD&D for Spouse Only Yes No Supp. Life for Dependent Child(ren) Yes No
 Amount of Employee Coverage Requested (Please specify in \$10,000 increments only): _____

NOTE: In order for dependents to qualify for a benefit selection, the employee must select the same benefit. Please indicate each member's name as you would like it to appear on the ID Card. ID cards are limited to 26 characters and spaces. If dependent has separate mailing address, please attach.

Add	Drop	Relationship	Last Name	First Name	M I	Social Security No.	Date of Birth	Gender		Benefit Selection		
								M	F	Med	Dent	Vis
<input type="checkbox"/>	<input type="checkbox"/>	Self				- -		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Spouse/ Domestic Partner				- -		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>					- -		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>					- -		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>					- -		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

For individuals who are eligible for enrollment in an employer group health plan: If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or employer group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if, in the case of employer group health plan coverage, the employer stops contributing toward you or your dependents' other coverage.) However, the request for enrollment must be received within 60 Days after you or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). In addition, if you gain a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 60 days after the marriage, birth, adoption, or placement for adoption.

4. Prior Medical Coverage

Prior Coverage?

Yes No (if 'Yes' indicate Prior Coverage on line below)

Prior Medical Carrier and Policy # (Please be sure to include the Trust/Association Full Name if plan was not direct through a medical carrier):

List all participants enrolled in prior medical plan:

Duration of coverage:

Eff. Date: _____ Term. Date: _____

5. Coordination of Benefits

Other Insurance Carrier:

Policy ID #:

Effective Date:

Policy Holder's Name:

Phone #:

Date of Birth:

Social Security #:
- -

If you have Medicare What is the Begin date for:

Part A:

Part B:

Medicare HIC # with Alpha Suffix:

6. Designation of Beneficiary

EMPLOYEE BENEFICIARY:	Primary Beneficiary Name and Relationship* for Basic Life/AD&D & Voluntary Life/AD&D	Primary Beneficiary Address	City	State	Zip
EMPLOYEE BENEFICIARY:	Contingent Beneficiary Name and Relationship** for Basic Life/AD&D & Voluntary Life/AD&D	Contingent Beneficiary Address	City	State	Zip

*** If more than one primary beneficiary is named, the primary beneficiaries shall share equally unless otherwise indicated above. ** Contingent Beneficiary(ies) will only receive proceeds if all Primary Beneficiaries have predeceased the Insured. If you are naming more than one Contingent Beneficiary at 100% each, please indicate them in order of precedence.**

7. Signature

I hereby apply for enrollment or change of enrollment as indicated on this application. I understand that the Health Alliance for Technology, a program under the Associated Employers Trust, and the Insurers may collect, use and disclose protected health information about each individual enrolled under this application in order to carry out their routine business functions, including but not limited to, determining eligibility for benefits, paying claims, coordinating benefits with other insurance carriers or payer, underwriting and conducting case management care management and quality reviews. The Health Alliance for Technology and the Insurers may also disclose protected health information to state and federal agencies, or other third parties, as required by law. I understand that information collected in connection with administration of the benefit plan may be used to bring to my attention health products or services that might be valuable to me and otherwise as permitted by law.

I understand that the health benefit plan that I have selected provides reimbursement for certain medical costs, which are more fully described in the current Certificate of Coverage. I understand there may be instances where treatment decisions made by my physician or me or medical expenses which I have incurred may not be covered by my health benefit plan.

The undersigned understands that it is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purposes of defrauding the company. Penalties include fines, imprisonment and denial of insurance benefits. Changes on this form supersede all previous forms submitted. I authorize my employer to deduct from my earnings the amount, if any, for the coverage selected.

Employee Signature	Date:	Employer Signature	Date:
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**Please return form to: Health Alliance for Technology, 1206 North Lincoln Suite 200, Spokane, WA 99201-2559
or fax to 509.777.2667 or email to alltech@aain.com**

UnitedHealthcare
9900 Bren Road East
Minnetonka, MN 55343

Unimerica
6300 Olson Memorial Hwy
MN010-W115
Golden Valley, MN 55427

UnitedHealthcare Benefit Services
250 North Patrick Blvd. Suite 125
Brookfield, WI 53045

Vision Service Plan
3333 Quality Drive
Rancho Cordova, CA 95670

Program Management provided by Wells Fargo Insurance Services