

Employee Enrollment Application, Cancellation, and Waiver – Clark County

Effective Date of Enrollment, Termination or Change:		Employer Name:		Medical: ☐ Add ☐ Delete	
Check One		Med Plan:		Dental: ☐ Add ☐ Delete	
☐ Open Enrollment ☐ Waiving		☐ New Enrollee ☐ COBRA		☐ Name Change ☐ Address Change	
		☐ Add Dependents ☐ Delete Dependents		☐ Cancellation	
Personal Information: (Please Print Clearly)					
Employee Name:		SSN:		Date of Birth:	
Last:				/ /	
First:		M.I:		/ /	
Mailing Address:		Hire Date:		Hours per week:	
City:		State:		Zip Code:	
Phone:		Marital Status:		Gender: ☐ Male ☐ Female	
Name of Enrolling Dependent(s):		Birth Date:		Relationship to Employee:	
Sex:		SSN:		Election	
Medical:		Dental:			
1)		2)		3)	
4)		5)		6)	
Relationship to Employee:		Sex:		SSN:	
Medical:		Dental:			
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Relationship to Employee:		Sex:		SSN:	
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Relationship to Employee:		Sex:		SSN:	
Medical:		Dental:			
1)		2)		3)	
4)		5)			

Employee Enrollment Application, Cancellation, and Waiver – Clark County**Terms & Conditions****Application Agreement**

I hereby apply for coverage under the contract between the issuer and my employer or group, and I agree with the terms of the contract. I also apply for the same coverage for my spouse or domestic partner, and/or my children listed on this application. I attest that my listed dependents and I meet all the eligibility criteria set forth in the outline of benefits and/or the contract.

I agree to pay in advance the appropriate rates for myself and listed dependents and authorize rate increases as the company deems necessary.

Anti-Fraud Statement

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. I have provided these answers as part of the application procedure required by the issuer to enroll in coverage and I attest that all information completed on this form is true, correct, and complete. I understand that the issuer will rely on each answer in making coverage and rating determinations.

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.

Medical Coverage Underwritten by: LifeWise Health Plan of Washington; 7001 220th St SW; Mountlake Terrace, WA 98043
Dental Coverage Underwritten by: Delta Dental of Washington; 400 Fairview Ave N; Seattle, WA 98109
Vision Coverage Underwritten by: VSP Vision Care, Inc.(HCSC); 11 S 12th St; Richmond, VA 23219
Life/AD&D Coverage Underwritten by: USABLE Life; 320 W Capitol Suite 700; Little Rock, AR 72201
Employee Assistance Program Coverage Underwritten by: First Choice Health Network, Inc.; 600 University Street, Ste 1400; Seattle, WA 98101

Administered by Rehn & Associates

Physical address:

1322 N Post St.
Spokane, WA 99201

Phone:

800-872-8979

Mailing address:

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