



P.O. Box 2113
Seattle, Washington 98111-2113

Enrollment Application

TYPE OR PRINT FIRMLY
(Leave shaded boxes blank)

CHECK ALL APPLICABLE BOXES

- Active Employee
- Early Retiree (not Medicare Eligible)
- Medicare Eligible Retiree
- Senior Partners Spouse/Dependent

New Members: Reason for Enrolling Now

- Open Enrollment New Hire
- Newly Retired Newly Medicare Eligible
- Other _____

Current Members: Reason for Enrollment Change

Date of Change | | | | | | | | | |

- Address Birth Death
- Name Marriage Divorce
- Adoption (Placement) Involuntary Loss of Coverage
- Other-Explain _____

Please complete these two boxes if you are a Senior Partners Spouse or Dependent →		SENIOR PARTNERS MEMBER NAME			SOCIAL SECURITY NUMBER		
APPLICANT - LAST NAME		FIRST		M.I.	SOCIAL SECURITY NUMBER		
HOME ADDRESS - STREET & NUMBER		APT. NO.	CITY		COUNTY	STATE	ZIP
HOME PHONE () ()		WORK PHONE () ()		EMPLOYER NAME		PRIMARY LANGUAGE, IF NOT ENGLISH	
(EMPLOYER USE) DATE OF HIRE OR DATE ENTERED ELIGIBLE CLASS, IF LATER		(EMPLOYER USE) EFFECTIVE DATE		(EMPLOYER USE) GROUP NUMBER		PREMERA HEALTHPLUS USE	

TO APPLICANT: PLEASE COMPLETE ALL BOXES FOR EACH PERSON LISTED BELOW, INCLUDING YOURSELF

If **new enrollment**, list all family members to be covered by this program. If **change in enrollment**, list only those members affected by the change. **Indicate each family member's Primary Care Practitioner**

ADD	DROP	RELATIONSHIP TO APPLICANT	LAST NAME	FIRST	M.I.	DATE OF BIRTH			SEX		SOCIAL SECURITY NUMBER	OTHER MEDICAL INS. (Y/N)	MEDI-CARE (Y/N)	COLLEGE STUDENT* (Y/N)	DIS-ABLED (Y/N)	EACH INSURED CAN CHOOSE A DIFFERENT PRIMARY CARE PRACTITIONER	
						MO	DAY	YEAR	M	F						PRIMARY CARE PRACTITIONER (FIRST AND LAST NAME)	PRACTITIONER NUMBER
		01 APPLICANT				MM	DD	YYYY									
		02 SPOUSE/DEPENDENT				MM	DD	YYYY									
		03 DEPENDENT				MM	DD	YYYY									
		04 DEPENDENT				MM	DD	YYYY									
		05 DEPENDENT				MM	DD	YYYY									
		06 DEPENDENT				MM	DD	YYYY									
		07 DEPENDENT				MM	DD	YYYY									
		08 DEPENDENT				MM	DD	YYYY									

* If dependent is full-time student, specify academic institution where enrolled _____

LIST ADDRESS OF EACH FAMILY MEMBER ENROLLED ABOVE IF DIFFERENT FROM APPLICANT

(PLEASE NOTE: If your dependent child has a permanent address outside the Premera HealthPlus service area, please contact Premera HealthPlus Member Services before enrolling him or her. See toll-free number on reverse side.)

1. NAME	STREET AND NUMBER	CITY	STATE	ZIP
2. NAME	STREET AND NUMBER	CITY	STATE	ZIP

I authorize my employer/group to deduct from my pay the amount, if any, for the coverage selected. I have listed above all family members to be covered by this program (applies to new enrollment only). **The changes on this form supercede all previous forms I have submitted.**

I hereby verify that all the information specified above is accurate and complete. I have also read, understand and agree to the provisions as stated on the reverse side.

PLEASE READ THE BACK OF THIS FORM BEFORE SIGNING.	SIGNATURE X	DATE SIGNED X
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PLEASE READ THE FOLLOWING IMPORTANT INFORMATION:

1. In applying for enrollment as indicated on this application, I declare that to the best of my knowledge, all of the information on this form is true and complete, and all of the persons for whom I am requesting enrollment are eligible for coverage. I authorize any health care provider to furnish Premera HealthPlus with any and all records pertaining to medical history, services rendered or treatment given to anyone who becomes enrolled under this application. This authorization shall commence immediately and shall remain in effect as long as needed to enable Premera HealthPlus to determine eligibility for benefits, pay claims, coordinate benefits with other insurance carriers, conduct studies, ensure the quality of care and services that enrollees receive and otherwise conduct routine health plan functions. I authorize Premera HealthPlus to disclose medical information to state or federal agencies, and other health care providers and carriers as necessary to conduct its routine health plan functions, or as required or permitted by law.
2. Each family member may choose a different Primary Care Practitioner (PCP).
3. EACH ENROLLED FAMILY MEMBER MUST SEEK ALL HEALTH CARE SERVICES FROM OR THROUGH HIS/HER PREMERA HEALTHPLUS PRIMARY CARE PRACTITIONER IN ORDER FOR SERVICES TO BE COVERED. SERVICES NOT AUTHORIZED BY THE MEMBER'S PRIMARY CARE PRACTITIONER WILL NOT BE COVERED, EXCEPT FOR MEDICAL EMERGENCIES AND OTHER SPECIFIED SERVICES.
4. If a Primary Care Practitioner is not selected we will assign a Primary Care Practitioner for you. Premera HealthPlus will send you a follow-up letter with the Primary Care Practitioner's name and location.
5. Changes requested in your Primary Care Practitioner choice will become effective on the first day of the month following Premera HealthPlus receipt of your request. You may change your Primary Care Practitioner by calling Member Services.
6. The submission of false or misleading information or the omission of material information on this form may result in rejection of your application or disenrollment retroactive to the original effective date.

HELPFUL HINTS FOR PREMERA HEALTHPLUS MEMBERS

- Select a Primary Care Practitioner who will provide and arrange for all your necessary health care.
- Before seeking health care services, call your clinic or Premera HealthPlus first!
- Identify yourself as a Premera HealthPlus Member whenever you seek health care.
- Always clarify with your Primary Care Practitioner in advance exactly how many specialist visits are authorized, so that you are not charged for unauthorized services.
- Keep your Primary Care Practitioner's name and phone number handy for easy reference. Your clinic name and 24 hour phone number is included on the front of your Premera HealthPlus I.D. Card.
- Know the emergency procedure at your clinic before you need emergency care.
- Questions? Call Member Services: In Western Washington call (425) 771-3111 or 1-800-527-6675.
In Eastern Washington call (509) 838-0660 or 1-800-542-9994.
Idaho residents call 1-800-626-0402.