BUSINESS HEALTH TRUST: KAISER PERMANENTE
AEROSPACE INDUSTRY HEALTH TRUST

Employee Enrollment & Change Form

Complete every applicable field and print clearly if you are filling this form out by hand. Section 1 is completed by the employer benefit administrator; sections 2 through 8 are completed by the employee.

Enter all dates as mm/dd/yyyy and Social Security numbers as xxx-xx-xxxx.

BEFORE YOU START

Fields outlined in **red** or with an asterisk* are required — an incomplete form will be returned
By providing your email address, you agree to receive plan documents through electronic delivery.

1. EMPLOYER SECTION

EMPLOYER NAME*				**MEDICAL GROUP #**		
DATE OF HIRE*				**EFFECTIVE DATE OF COVERAGE***		
WORKSITE LOCATION* (STATE)				**HOURS PER WEEK***		
EMPLOYEE CLASS (IF ANY)				**SALARY AMOUNT**	$	
SALARY FREQUENCY	☐ Annually	☐ Monthly	☐ Semi-monthly	☐ Bi-weekly	☐ Weekly	☐ Hourly
REASON FOR ENROLLMENT, QUALIFYING LIFE EVENT (QLE) **CHANGE OR TERMINATION**	☐ New Hire	☐ Open enrollment	☐ Loss of prior coverage	☐ COBRA		
	☐ Rehire	☐ Add dependent(s)	☐ Voluntary termination	☐ Name change		
	☐ Marriage	☐ Drop dependent(s)	☐ Involuntary termination	☐ Address change		
	☐ Divorce	☐ Birth / adoption	☐ Other:			
QUALIFYING LIFE EVENT DATE (QLE)		**CHANGE DATE**		**TERMINATION DATE**		

2. EMPLOYEE INFORMATION

FIRST NAME*		**MIDDLE INITIAL**		**LAST NAME***	
DATE OF BIRTH*		**GENDER AT BIRTH***	☐ Male ☐ Female	**MARITAL STATUS***	☐ Married ☐ Single
MAILING ADDRESS*				**SOCIAL SECURITY #***	
CITY*		**STATE***		**ZIP***	
PHONE*				**EMAIL***	

3. PLAN SELECTIONS

If your employer offers more than one medical plan, write the name of the plan in the field below.
If you are waiving coverage, leave the field blank and complete Kaiser's Waiver of Coverage Form.

MEDICAL PLAN NAME	

4. EMPLOYEE AND DEPENDENT ENROLLMENT

ELECT	DROP	RELATIONSHIP	FIRST NAME	MI	LAST NAME	SOCIAL SECURITY #	DATE OF BIRTH	SEX M/F	MED	DEN	VIS
☐	☐	Self							☐	☐	☐
☐	☐	☐ SP[1,2] ☐ DP[1,2]							☐	☐	☐
☐	☐	Child[3]							☐	☐	☐
☐	☐	Child							☐	☐	☐
☐	☐	Child							☐	☐	☐
☐	☐	Child							☐	☐	☐
☐	☐	Child							☐	☐	☐

[1] SP = spouse; DP = domestic partner (affidavit required). [2] Attach separately if a dependent's mailing address differs. [3] Child 26 or older: attach an Affidavit of Qualifying Incapacitated Dependent Eligibility.
Dependents must enroll in the same benefits as the employee. Write each name exactly as it should appear on the ID card (26-character limit, including spaces).

5. ELIGIBILITY AND SPECIAL ENROLLMENT RIGHTS

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/domestic partner) 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, you should request enrollment 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 should request enrollment within 60 days of the marriage, birth, adoption, or date of assumption of total or partial legal obligation for support of a child in anticipation of adoption.

Dependents are not required to reside with the subscriber. Dependents are not required to be dependent upon the subscriber for support. Eligibility for medical assistance is not considered when determining eligibility for coverage or making payments. Dependent children are eligible for coverage through the age of 25 regardless of marital status, student status or eligibility for coverage under another plan. Washington State Registered Domestic Partners are treated the same as a spouse. If children of the primary insured are covered, children of Domestic Partners are eligible for coverage on the same basis.

6. VOLUNTARY LIFE ENROLLMENT

Only available if elected by your employer.

ELECT	DROP	RELATIONSHIP	ELECTION AMOUNT	INCREMENTS / MAX	GUARANTEE ISSUE (GI)	EVIDENCE OF INSURABILITY (EOI)
☐	☐	Self	$	$5,000 / $300,000	$100,000	Required above Guarantee Issue

7. BENEFICIARY DESIGNATION FOR EMPLOYER-PAID LIFE /AD&D AND VOLUNTARY LIFE

If you are enrolled in medical, a Life/AD&D benefit of at least $15,000 is included with your medical coverage; your employer may elect a higher amount. Attach a separate sheet to name more beneficiaries.

BENEFICIARY TYPE	FIRST NAME	LAST NAME	DATE OF BIRTH	ADDRESS, CITY, STATE, ZIP	RELATIONSHIP	%
☐ Primary ☐ Contingent						
☐ Primary ☐ Contingent						
☐ Primary ☐ Contingent						
☐ Primary ☐ Contingent						

Primary beneficiaries must total 100%. Contingent beneficiaries must also total 100%. Multiple primary beneficiaries share equally unless you indicate otherwise. Contingent beneficiaries receive proceeds only if all primary beneficiaries have predeceased the insured; if naming more than one at 100% each, list them in order of precedence.

8. SIGNATURES

I hereby apply for enrollment or change of enrollment as indicated on this application.

I understand that the 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 Trust 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.

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 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.

I authorize my employer to deduct from my earnings the amount, if any, for the coverage selected.

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 the appropriate Endorsed Carrier listed below.

The 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.

Please note: To avoid processing delays, please be sure all applicable fields are completed and clearly legible if filled out by hand.

EMPLOYEE SIGNATURE*		**DATE***	
EMPLOYER SIGNATURE*		**DATE***	

QUESTIONS

CONTACT	FOR	HOW TO REACH THEM
VIMLY BENEFIT SOLUTIONS	**Enrollments, changes and waivers**	Vimly Benefit Solutions · bht@vimly.com PO Box 6 · Mukilteo, WA 98275-0006 · 425.771.7359
KAISER PERMANENTE	**Medical**	Kaiser Foundation Health Plan of Washington 2715 Naches Ave. SW · Renton, WA 98057 · 888.901.4636
KAISER PERMANENTE	**Medical**	Kaiser Foundation Health Plan of Washington Options, Inc. 2715 Naches Ave. SW · Renton, WA 98057 · 888.901.4636
DELTA DENTAL	**Dental**	Delta Dental of Washington 400 Fairview Avenue North, Suite 800 · Seattle, WA 98109 · 800.554.1907
VSP	**Vision**	VSP Vision Care Inc 3333 Quality Drive · Rancho Cordova, CA 95670 · 800.877.7195
USAble Life	**Life / AD&D and Voluntary Life**	USAble Life PO Box 1650 · Little Rock, AR 72203 · 800.370.5856
TELUS Health	**Employee Assistance Program (EAP)**	Telus Health 27715 Jefferson Avenue, Suite 103 · Temecula, CA 92590 · 888.577.3784
AIG	**Personal Accident**	National Union Fire Insurance Company of Pittsburgh, Pa. (an AIG Company) 1271 Ave of the Americas FL37 · New York, NY 10020-1304 · 212.770.7000
norton LifeLock Benefit Solutions	**ID Theft**	Norton LifeLock Benefit Solutions US HQ, 60 E. Rio Salado Pkwy Ste. 1000 · Tempe, AZ · 85281 · 800.607.9174
nice	**Integrated Primary Care Clinic**	Nice Healthcare 2355 Highway 36 W, Suite 400 · Roseville, MN 55113 · 888.642.7332