GroupHealth COOPERATIVE GroupHealth OPTIONS, INC.

P.O. Box 34750
Seattle Washington 98124-9745

EMPLOYEE ENROLLMENT and CHANGE FORM

EMPLOYER: PLEASE COMPLETE THIS SECTION

Coverage Effective Date _____

Group Name NASRO

Group Number 5166100

**Group number should match health plan choice, if selected by employee in section below.*

Original Date of Hire ___/___/___

Date of Rehire ___/___/___

Date Transferred From Part (P/T) to Full Time (F/T) ___/___/___

Hours Worked Per Week _____

If Retired, Date of Retirement ___/___/___

Choose one:

☐ Open Enrollment ☐ New Employee

☐ Address/Name Change ☐ Add Dependent(s)

☐ Remove Coverage

___ Subscriber ___ Dependent(s)

Date processed _____ By _____

☐ **Transfer to COBRA**

Start Date _____

☐ 18 months

☐ 36 months

EMPLOYEE: COMPLETE THE FOLLOWING NON-SHADED AREAS. PLEASE PRINT.

Employee Name _____ (Last Name) (First Name) (M.I.) Marital Status: ☐ Married ☐ Single Date Married ___/___/___

Mailing Address _____ Home Phone (_____) _____

Resident Address _____ (Street) (City) (State) (Zip) Work Phone (_____) _____

Employee Medicare Claim # _____ Former Name of Applicant or Spouse _____

***HEALTH PLAN CHOICE** *If more than one health plan is offered, please write in your choice, including the group number.*

Health plan _____ Group number _____

For Health Plan Internal Use Only	CHECK ONE Add	Remove	PLEASE PRINT Last Name	First Name	M.I.	Social Security Number	Sex	Birthdate (mm/dd/yy)	Relationship to Employee	List Personal Physician Name/Medical Center	Current Patient? Yes	No
			SELF						**SELF**			
			DEPENDENT									
			DEPENDENT									
			DEPENDENT									
			DEPENDENT									
			DEPENDENT									

DEPENDENT ELIGIBILITY INFORMATION *Please list names of **married dependents:***

1. _____ (Last Name) (First Name) (M.I.)

2. _____ (Last Name) (First Name) (M.I.)

Please list names of any **dependents who are Medicare-eligible or disabled and their Medicare number:**

1. Spouse Medicare Claim # _____ 2. Dependent Name _____ Medicare Claim # _____

ADDITIONAL HEALTH BENEFITS INFORMATION

Other insurance (that is *not* a Group Health, Options, or Alliant health plan): _____

Who is the subscriber under this plan? _____

What is their social security or policy number with this plan? _____ **Attach any certificate of creditable coverage letters to the back of this form.**

_____ **(Signature of Employee)**

_____ **(Date Signed)**

Please notify us in writing of any changes to address or family status.

WHITE COPY – SEND TO HEALTH PLAN **YELLOW COPY** – EMPLOYER RETAIN