

PREMERA EDUCATION PROGRAM ENROLLMENT AND CHANGE APPLICATION

School District Name: Highline School District				Group Number: 4012344		<input type="checkbox"/> New Enrollment		<input type="checkbox"/> Change Enrollment	
Employee Information									
Employee Name (Last)		(First)	(MI)	Premera ID Number (if enrolled)			Home Phone ()		
Mailing Address			City			State	ZIP		
Email Address:		Classification: <input type="checkbox"/> Administrator <input type="checkbox"/> Certificated <input type="checkbox"/> Non-represented <input type="checkbox"/> Classified <input type="checkbox"/> Other:							
Will you or your dependent(s) enrolled on the plan have any other <u>active</u> medical or Medicare coverage when this coverage begins? <input type="checkbox"/> No <input type="checkbox"/> Yes , please complete and attach an Other Coverage Questionnaire form.									
Is any child over the dependent age limit applying for coverage due to a disability? <input type="checkbox"/> No <input type="checkbox"/> Yes , complete and attach the Request for Certification of Disabled Dependent form.									
Medical Plan Selection and Enrollment (Not all districts or employer groups offer all plans. PLEASE See <u>Enrollment Notes</u> on the reverse side.)									
Medical <input type="checkbox"/> Waive <input type="checkbox"/> Plan 2 <input type="checkbox"/> Plan 3 <input type="checkbox"/> Plan 5 <input type="checkbox"/> EasyChoice A <input type="checkbox"/> EasyChoice B <input type="checkbox"/> Basic <input type="checkbox"/> QHDHP									
	Please list <u>ALL</u> enrollees to be covered, added or dropped on your plan Note: Names on ID cards are limited to 26 characters and spaces				Gender	Birth Date	Premera Medical		
	Last Name	First Name	M.I.	Social Security Number	M / F	(Mo./Day/Yr.)	Add	Drop	
Self							<input type="checkbox"/>	<input type="checkbox"/>	
Spouse/DP							<input type="checkbox"/>	<input type="checkbox"/>	
Child:							<input type="checkbox"/>	<input type="checkbox"/>	
Child:							<input type="checkbox"/>	<input type="checkbox"/>	
Child:							<input type="checkbox"/>	<input type="checkbox"/>	
Child:							<input type="checkbox"/>	<input type="checkbox"/>	

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 have also read and understand the provisions as stated on the reverse side. 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. **Be sure to sign your application.** Please keep a copy for your records and give the signed application to your school district.

Employee Signature: **X** **Date Signed:**

Note: 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.

To be completed by School District — Print a copy for your records and send the signed application to Premera.				
Check Appropriate Enrollment Box and Provide Date: <input type="checkbox"/> New Employee <input type="checkbox"/> Insurance Eligible <input type="checkbox"/> Open Enrollment <input type="checkbox"/> Dependent Change		Date of Qualifying Event / /		Effective Date of Insurance / /
Change of Status: <input type="checkbox"/> Marriage/Domestic Partnership <input type="checkbox"/> Divorce/End of Domestic Partnership <input type="checkbox"/> Death <input type="checkbox"/> Surviving Dependents <input type="checkbox"/> Birth <input type="checkbox"/> Special Enrollment Legal documentation is attached for: <input type="checkbox"/> Adoption <input type="checkbox"/> Medical Child Support Order <input type="checkbox"/> Legal Guardianship/Non-parental Custody				
Loss of Other Coverage—Reason:			Date Prior Coverage Ended: / /	
Premera Blue Cross Use Only	ID Number:	ID Card:	Date: / /	Initials:

PREMERA PRIVACY POLICY PRACTICES

We may collect, use, or disclose personal information about you, including health information, your address, telephone number or Social Security number. We may receive this information from, or release it to, healthcare providers, insurance companies, or other sources to conduct our routine business operations such as: underwriting and determining your eligibility for benefits and paying claims; coordinating benefits with other healthcare plans; conducting care management, case management, or quality reviews. This information may also be collected, used or released as required or permitted by law.

To safeguard your privacy and ensure your information remains confidential, we train all employees on our written confidentiality policy and procedures. If a disclosure of your personal information is not related to a routine business function, we will remove anything that could be used to easily identify you, unless we have your prior authorization to release such information.

You have the right to request inspection and/or amendment of your records retained by us. To view or print copies of our detailed Privacy Notice and other forms, please visit our web site at premera.com. To have forms mailed to you, please call Premera customer service at 855-756-0798.

ENROLLMENT NOTES

Please Note: Not all school districts offer all plans listed. Please choose only from the plans made available to you by your school district or employer group. Contact your school district or employer group to learn about which plans are available to you.

- Complete all sections of the Premera Education Program Enrollment and Change Application except the portion that is reserved for use by your school district and Premera Blue Cross.
- List ALL eligible family members to be covered, added or dropped on your plan and check the appropriate box to the right of each name.
- Please indicate each dependents name on the enrollment application as you would like it to appear on the ID card.
Note: ID card names are limited to a maximum of 26 characters and spaces.

Medical plan selection and enrollment (Underwritten by Premera Blue Cross, PO Box 327, Seattle, WA 98111)

Please choose only from the plans made available to you by your school district or employer group. Not all school districts and employer groups offer all medical plans. Contact your payroll office or benefits administrator for more information.

For additional information on dependent eligibility, refer to your benefit booklet or go to premera.com.