UNITE HERE HEALTH
ALASKA HERE PLAN

PLEASE PRINT

HEALTH ENROLLMENT FORM

F41

INSTRUCTIONS: Please provide all information indicated below and sign the form. **If you want dependent coverage, you must make a self-payment on the 20th of the month *prior* to the month of coverage.** Mail one copy to: Administration Office, P.O. Box 34203, Seattle, WA 98124. Retain a copy for your records. **A COMPLETED ENROLLMENT FORM MUST BE ON FILE AT THE ADMINISTRATION OFFICE BEFORE CLAIMS CAN BE PROCESSED.**

☐ New Employee ☐ Address Change ☐ Change Dependent(s) ☐ Open Enrollment ☐ Name Change _____ (Previous Name)

Employee Name *(Last, First, M.I.)*	Social Security Number	Birth Date *(M/D/Y)*	Sex *(M/F)*
Mailing Address *(Street or P.O. Box)*	City	State	Zip Code
Home Phone	Cell Phone	Email Address	

Dependent Coverage Election:

☐ **Yes, I Elect Dependent Coverage.**
I apply for coverage for my spouse and/or dependent children listed on this form and I understand that I must make payment for dependent coverage on the 20th of the month prior to the month of coverage. Check the appropriate box for the number of dependent(s) you wish to cover.
☐ **1 Dependent** ☐ **2 or More Dependents** ***Important: Complete Other Insurance Information below.***

☐ **I Do Not Elect Dependent Coverage.**
Note: If you do not elect dependent coverage at this time, your dependents will not have coverage. You will not have the opportunity to enroll them until the next open enrollment period.

DEPENDENTS NAME *(Last, First, M.I.)* ***Only list dependents if you elected dependent coverage above.***	**SOCIAL SECURITY NUMBER**	**SEX** *(M/F)*	**BIRTH DATE** *(M/D/Y)*	**RELATIONSHIP TO EMPLOYEE**	**Check if Step, Foster or Adopted Child**
Spouse				**Date of Marriage:**	
Dependent Children					

Other Insurance Information: **YOU MUST COMPLETE THIS SECTION.**

1. Are you, your spouse, or other dependents covered by any other group medical insurance plan including Medicare? ☐ Yes ☐ No
If "YES," please provide the information below. If covered by Medicare, a copy of your Medicare ID card must be on file with the Administration Office.

Name of Person with Other Coverage — Social Security Number

Name of Other Insurance Company — Policy or I.D. Number

Address of Other Insurance Company — City, State and Zip

2. Insurance Covers: ☐ Employee ☐ Spouse ☐ Children 3. Date Coverage Began: _____

I hereby certify that the above information is true, correct and complete to the best of my knowledge. The above information will be used to determine eligibility for claim/benefit purposes. I am aware of the following, "A person who knowingly and with intent to injure, defraud or deceive an insurance company files a claim containing false, incomplete or misleading information is guilty of a felony." (Alaska Insurance Code Section 21.36.380)

Signature (*must be signed by participating employee)* — Date

RETURN A COPY TO THE ADMINISTRATION OFFICE: P.O. BOX 34203 – SEATTLE, WA 98124-1203
Scan and email to: forms@wpas-inc.com or Fax to: (206) 505-9727

RETAIN A COPY FOR YOUR RECORDS