

# Tulalip Tribes of Washington Group 4137 Employee Medical Enrollment

Location:  Admin #100  Casino/Bingo #300  TGA #400  Quil Ceda Village #500  Pharmacy #600

Date Hired: \_\_\_\_\_ Reason: \_\_\_\_\_ Effective Date: \_\_\_\_\_

## EMPLOYEE INFORMATION:

TGO Clock-In # \_\_\_\_\_ Department: \_\_\_\_\_  Tulalip Native American  
 Native American Non-Tulalip  
 Soc. Sec. # \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Gender:  M  F  
 Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ M.I. \_\_\_\_\_  
 Mailing Address \_\_\_\_\_ City \_\_\_\_\_  
 Telephone Number (\_\_\_\_) \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

## I ELECT TO WAIVE THE MEDICAL PLAN OFFERED ON THIS FORM

I understand that the next opportunity to enroll in this plan is during the annual open enrollment period

**PLAN SELECTION:** Please choose one medical plan. *Note: Dependents must be enrolled in the same plan as the employee.*

### MEDICAL (VISION, RX) PLANS

BRONZE PLAN	GOLD PLAN	PLATINUM PLAN
\$1,500 DEDUCTIBLE/70% COINSURANCE	\$500 DEDUCTIBLE/90% COINSURANCE	\$0 DEDUCTIBLE/100% COINSURANCE
<input type="checkbox"/> Myself (\$0 per mo.)	<input type="checkbox"/> Myself (\$88.14 per mo.)	<input type="checkbox"/> Myself (\$177.40 per mo.)
<input type="checkbox"/> Myself with 1 Child (\$42.34 per mo.)	<input type="checkbox"/> Myself with 1 Child (\$183.37 per mo.)	<input type="checkbox"/> Myself with 1 Child (\$326.18 per mo.)
<input type="checkbox"/> Myself with 2+ Children (\$119.96 per mo.)	<input type="checkbox"/> Myself with 2+ Children (\$357.95 per mo.)	<input type="checkbox"/> Myself with 2+ Children (\$598.94 per mo.)

Company Paid Life Insurance: Bronze & Gold Plan \$25,000

Platinum Plan \$35,000

## ENROLLMENT INFORMATION

(Name, SSN, Sex, Date of Birth & Relationship (required). If adding due to adoption, court order or legal guardianship, attach documentation.

\*Relationship Key: S = Son D = Daughter DPS = Domestic Partner's Son DPD = Domestic Partner's Daughter

SAME	ADD	DROP	Last Name, First Name, M.I.	SSN	Sex	Date of Birth	Relationship	Enrolled TTW	Enrolled OTHER Native American

Employee's Signature \_\_\_\_\_ Date Signed \_\_\_\_\_

By signing this form I acknowledge and agree to the terms on the back of this page.

**By signing this form:**

*\*I certify that the above listed information is correct and that I am enrolling only eligible dependents as defined in the Plan Document. I understand that all entitlements to benefits are void, and coverage may be canceled or modified retroactively to its effective date, if I have made intentionally false or misleading statements or answers on behalf of myself or any family members. I authorize any person or institution providing care or services, or any organization in possession of insurance benefit information to release any and all information pertaining to the care or benefits provided to me or my dependents to Healthcare Management Administrators or its designated agent.*

*I acknowledge and understand that my health plan may request or disclose health information about me or my dependents (persons who are listed for benefits coverage on the enrollment form) from time to time 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: 1) A physician, dentist, pharmacist or other physical or behavioral health care practitioner; 2) A clinic, hospital, long term care or other medical facility; 3) Any other institution providing care, treatment, consultation, pharmaceuticals or supplies; or 4) 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, 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.*

*\* For more information about such uses and disclosures, including uses and disclosures required by law, please refer to the Privacy Notice. A copy is available upon request.*

**Changes: Plans can only be changed at the October open enrollment period of the year. A dependent can only be dropped from coverage during the annual open enrollment period, unless there is a qualifying event, such as the person becomes covered under another plan, or loss of employment.**

**Salary Deduction Agreement: I understand I have the right to have the company redirect my salary on a PRETAX basis during the plan year & apply this premium amount toward the purchase of the medical coverage I have designated. I understand that my share of the cost of this coverage may be adjusted to reflect the change in rates. I authorize the company to adjust my pay as required by my elections on this form.**