

EMPLOYER SECTION: Location: Admin #100 Casino/Bingo #300 TGA #400 Quil Ceda Village #500 Pharmacy #600 Special Enrollment: _____

Date Hired: _____ Coverage Effective Date: 5-1-2014 Effective Date of Change: _____ Certified by: _____ Today's Date: _____

EMPLOYEE INFORMATION:

ADMIN BINGO TULALIP CASINO QCC HOTEL Tulip Native American
 Clock-In # _____ Department: _____ Native American Non-Tulalip
 Soc. Sec. # _____ Date of Birth ____/____/____ Gender: M F Telephone Number (____) _____
 Participant Last Name _____ First Name _____ M.I. _____
 Mailing Address _____ City _____ State _____ Zip Code _____

Reason for Completing Form (check one):

- New Enrollee Military Leave of Absence - Date returned from MLOA: _____
 Open Enrollment – Coverage effective November 1st Limited Enrollment (add dependents only) Coverage effective May 1st
 Status Change - Temporary to Permanent Newborn Marriage Loss of dependents previous coverage Dental Only – Minimum age 5 reached

PLAN SELECTION: Please choose one medical and one dental plan. DEPENDENTS MUST HAVE THE SAME PLANS AS THE EMPLOYEE PARTICIPANT:

<p>Choose one medical & one dental</p> <p>Base: no charge for employee coverage; charge for dependents.</p> <p>Buy-up: increased premiums for employee & dependents.</p>	<p align="center">Medical (Vision, RX) Plans with Monthly Cost</p> <p>Base <input type="checkbox"/> Myself \$0 per Month <input type="checkbox"/> Myself & Child(ren) \$200</p> <p>Buy-Up <input type="checkbox"/> Myself \$124.14 per Month <input type="checkbox"/> Myself & Child(ren) \$555.80</p>		<p align="center">Dental Plans with Monthly Cost</p> <p>Base <input type="checkbox"/> Myself \$0 per Month <input type="checkbox"/> Myself & Spouse/Domestic Partner \$33.00 <input type="checkbox"/> Myself & 1 Child \$33.00 <input type="checkbox"/> Myself & Children \$74.00 <input type="checkbox"/> Myself, Spouse/DP & Child(ren) \$74.00</p> <p>Buy-Up <input type="checkbox"/> Myself \$13 per Month <input type="checkbox"/> Myself & Spouse/Domestic Partner \$58.00 <input type="checkbox"/> Myself & 1 Child \$58.00 <input type="checkbox"/> Myself & Children \$111.00 <input type="checkbox"/> Myself, Spouse/DP & Child(ren) \$111.00</p>		<p align="center">Medical Waived Life EE only</p> <p align="center"><input type="checkbox"/></p>

ENROLLMENT INFORMATION (Please provide sex, date of birth, relation, and SSN (required). If adding due to adoption, court order or legal guardianship, documentation is required.

*Relationship Key: SP = Spouse S = Son D = Daughter DP = Domestic Partner DPS = Domestic Partner's Son DPD – Domestic Partner's Daughter

Add	Drop	Last Name, First Name, M.I.	Social Security Number	Sex	Date of Birth	Relationship*	Native American Enrolled Tulalip	Native American Enrolled Non-Tulalip
[] Medical [] Dental	[] Medical [] Dental						Yes: <input type="checkbox"/>	Yes: <input type="checkbox"/>
[] Medical [] Dental	[] Medical [] Dental						Yes: <input type="checkbox"/>	Yes: <input type="checkbox"/>
[] Medical [] Dental	[] Medical [] Dental						Yes: <input type="checkbox"/>	Yes: <input type="checkbox"/>
[] Medical [] Dental	[] Medical [] Dental						Yes: <input type="checkbox"/>	Yes: <input type="checkbox"/>
[] Medical [] Dental	[] Medical [] Dental						Yes: <input type="checkbox"/>	Yes: <input type="checkbox"/>
[] Medical [] Dental	[] Medical [] Dental						Yes: <input type="checkbox"/>	Yes: <input type="checkbox"/>
[] Medical [] Dental	[] Medical [] Dental						Yes: <input type="checkbox"/>	Yes: <input type="checkbox"/>
[] Medical [] Dental	[] Medical [] Dental						Yes: <input type="checkbox"/>	Yes: <input type="checkbox"/>

PREVIOUS insurance information:

Have you or your dependents had coverage within 63 days of date of hire prior to enrollment in this plan? Yes No

Type of coverage: Medical Dental Vision

If yes, please request a Certificate of Creditable Coverage (CCC) from your previous insurance provider for all enrolled members.

CCC attached

Coordination of Benefits Information:

Do you or any dependent have health coverage IN ADDITION TO this health plan? Yes No

If yes, please complete the "CO-ORDINATION OF BENEFITS INFORMATION FORM."

Life Insurance beneficiary information MUST BE COMPLETED

Life Insurance: May list one or more beneficiaries. List additional beneficiaries on a separate sheet of paper and attach it to this enrollment form. If listing one beneficiary, that individual will receive 100% of the benefit. Please indicate percentage of benefit for multiple beneficiaries. Total percentages must equal 100%.

Beneficiary: _____ **Phone #** _____ **Relationship:** _____ **Percentage:** _____

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Beneficiary: _____ **Phone #** _____ **Relationship:** _____ **Percentage:** _____

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, 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.

** 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.*

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

Change of Plans, (buy-up to base or base to buy-up) can only be changed at the second open enrollment of the year.

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/dental 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.

Employee's Signature _____ **Date Signed** _____

Employee Name (Printed): _____