GroupHealth®

12401 E. Marginal Way S., Tukwila, WA 98168
P.O. Box 34750, Seattle, WA 98124-9745

Employee enrollment and change form

EMPLOYER: PLEASE COMPLETE THIS SECTION.

Coverage effective date _____

Group name _____

Group number _____

Pay location (if applicable) _____

Original date of hire ___ / ___ / ___

Date of rehire ___ / ___ / ___

Date transferred from part time (p/t) to full time (f/t) ___ / ___ / ___

Hours worked per week _____

If retired, date of retirement ___ / ___ / ___

Choose one:

☐ Open enrollment ☐ Add dependent(s)

☐ New employee ☐ Remove coverage

☐ Address/name change ___ Subscriber ___ Dependent(s)

☐ Qualifying event _____

Date processed ___/___/___ by _____

☐ **Transfer to COBRA**

Start date ___/___/___

☐ 18 months

☐ 36 months

EMPLOYEE: COMPLETE THE FOLLOWING. PLEASE PRINT.

Employee name _____
(Last name) (First name) (M.I.)

Resident address _____
(Street) (City) (State) (ZIP)

Mailing address (if different) _____

Former name of applicant or spouse (if applicable) _____

Work phone ( ) _____

Home phone ( ) _____

E-mail address* _____

*By providing your e-mail address, you are agreeing to receive e-mail communications from Group Health.

Selected health plan: _____

For health plan internal use only	Check one		Please print Last name	First name	M.I.	Social Security number (required)	Male/ Female	Birthdate (MM/DD/YY)	Relationship to employee
	Add	Remove							
			Self						
			Spouse/domestic partner/dependent (circle one)						
			Dependent						
			Dependent						
			Dependent						

☐ I would like to become a voting member of Group Health Cooperative.

☐ My eligible dependents (age 18 and older) would like to become voting members of Group Health Cooperative.

_____

(Signature of employee) **(Date signed)**

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.