## City of Redmond EMPLOYEE HEALTH CARE ENROLLMENT AND CHANGE FORM Group Number: 4040

For HMA Use Only					
In System					
To CVS					
Elig. Rep. Initials _					

				-				
☐ Change in Enrollment Status ☐ New Enrollment	ollee (Employee) ☐ Plan C	hange □ Name Chanç	ge □ Address Cha	ange				
☐ Drop Spouse/Domestic Partner/Dependen	Partner/Dependent Reason:Spouse/Domestic Partner/Dependent Coverage End Date:							
☐ Add Spouse/ Domestic Partner/Dependent	Reason:	Spouse/Domestic Pa	rtner/Dependent Ef	fective Date:				
If Adding Spouse or Domestic Partner, Date	of Marriage or Registration:		Effective D	Date of Change:				
(If adding dependent(s) due to adoption, cour of your marriage certificate or Washington Ce	t order, or legal guardianship	, you must provide legal	documentation. Y	ou may be required to provide a copy				
□ Rehire Date:	□ Leave of A	lbsence □ Date	e returned from LO	A:				
EMPLOYEE INFORMATION:								
Soc. Sec. #	Date of Birth/	<u>/</u> <b>Sex</b> : □ M □ F	Telephone Numb	per ( )				
Participant Last Name	Fir	st Name		M.I				
Mailing Address	c	City		Zip Code				
> Indicate Plan Selection and Er	rollment Status. You	MUST ENROLL YOUR	SELF IN ORDER T	O COVER ANY DEPENDENTS:				
Red-Med - MEDICAL	Red-Med - DENTAL		Group Health					
☐ Myself	□ Myself		☐ Myself	□ Myself				
☐ Spouse or Domestic Partner	☐ Spouse or Dom	estic Partner	☐ Spouse or D	☐ Spouse or Domestic Partner				
□ Child(ren)	□ Child(ren)		☐ Child(ren)	□ Child(ren)				
Sex, date of birth, and social sec  First Name M.I. Last Name  If dropping spouse/domestic partner/dependent Name:  Name:	sex  Ints please list name(s):  Term date:  Term date:	Date of Birth  Reas Reas Reas	Relationship: SP=Spouse EC=Employee DP=Domestic DPC=DP Child	e's Children Partner dren Social Security #				
Prior Insurance Coverage Information (for		, ,						
Have you (or spouse or domestic partner) had <i>If yes, attach a copy of any Certificate(s) o</i> Type of coverage: □ Medical □ Dental □ Vis	f Creditable Coverage.	·						
1,790 of coverage. In Medical In Defital In Vis								
List yourself and any family member(s) listed member is different than the employee's, atta				or termination date for any family				
Disabled Dependent Eligibility/								

List child who is developmentally disabled or physically handicapped who is  ${\bf over}$  age 25:

Name: \_\_\_\_\_\_ Medical documentation must be submitted within 31 days of the effective date of coverage.

## This section MUST be completed in order for your enrollment to be processed.

## **Coordination of Benefits Information**

Currently do you, your spouse/domestic partner or any dependent children have coverage through another insurance plan? 

YES NO If no, please sign and date form below. If yes, please complete the following, then sign and date form:

EMPLOYEE MARITAL STATUS:   SINGLE   DOMESTIC PARTNER	MARRIED 🗖 WIDOWED							
IF DIVORCED, IS THERE A COURT ORDER FOR P COURT DECREE:	ROVISION OF THE CHILI	D? YES NO/IF	YES, PLEASE ATTACH	A COPY OF THE COL	JRT DECREE. PER THE			
WHO HAS CUSTODY OF THE CHILD?	WHO	NEEDS TO PROVIDE	INSURANCE FOR THE	CHILD?				
PLEASE LIST THE FULL NAME OF THE CHILD(RE	N)							
DI FACE LICT DOTLITUE MATURAL DARFATO MA	ME AND DATE OF DIDTIL	NATURAL FATUER		/ DATE OF DIDTU				
PLEASE LIST BOTH THE NATURAL PARENTS NAME AND DATE OF BIRTH: NATURAL FATHE		·	/ DATE OF BIRTH					
List all family mamber(s) including yourse	lf who are included a							
List all family member(s), including yoursel					i another plan.			
Name of covered members:	Type of Coverage: (M)edical (D)ental (V)ision	Type of Policy: (G)roup (I)ndividual	Effective date of coverage:	Carrier Name:				
			//					
			/					
			/					
			/					
Provide the following information on the ca	arriers listed above:							
Carrier Name:	lame: Policy/Group Number:							
Street Address:		City:		State	Zip			
Carrier phone #:								
Subscriber's Name:	Social Secu	rity Number:		Date of birtl	n:			
Employer's Name and Address (if group cover	rage)							
Carrier Name:	Policy/Group Number:							
Street Address:		City:		State	Zip			
Carrier phone #:								
Subscriber's Name:	Subscriber's Name: Date of birth:							
Employer's Name and Address (if group cover	rage)							
IS EMPLOYEE or SPOUSE/DOMESTIC PAR	TNER COVERED UND	DER THIS MEDICAL	. PLAN ELIGIBLE FO	OR MEDICARE BEN	EFITS? YES NO			
IF YES, ENTER DATE OF ELIGIBILITY FOR	MEDICARE PART A _	DA	TE OF ELIGIIBILIT	Y FOR MEDICARE F	PART B			
SOCIAL SECURITY NO								
I certify that the above listed information is corentitlements to benefits are void, and coverage misleading statements or answers on behalf organization in possession of insurance benefice dependents to Healthcare Management Administration.	e may be canceled or r f myself or any family r it information to release	modified retroactively members. I authoriz e any and all informa	, / to its effective date e any person or insti	, if I have made inter tution providing care	ntionally false or or services, or any			
Employee's Signature				Date Signed	/ /			
EMPLOYER SECTION								
Group Number 4040 Location Number	er	Job Title						
Date Hired:/ Co	verage Effective Date:		Effective	Date of Change: _	1 1			
Late Enrollment: ☐ Yes ☐ No	Special	Enrollment: ☐ Yes	☐ No (If yes, attach	waiver of health cove	erage)			
Certified by:			Today's	Date: /	/			