Northwest Automotive Trades Association Health Plan
Employee Enrollment Application, Cancellation, and Waiver

Effective Date of Enrollment, Termination or Change:	**/01/**	**Employer Name:**		**Medical:**	❑ Add ❑ Delete
				Dental:	❑ Add ❑ Delete
Check One	❑ Open Enrollment ❑ New Enrollee ❑ Name Change ❑ Add Dependents ❑ Cancellation ❑ Waiving* ❑ COBRA ❑ Address Change ❑ Delete Dependents			**Med Plan:**	
				Class:	

Personal Information: (Please Print Clearly)

Employee Name:	Last:			**SSN:**	
	First:		M.I:	**Date of Birth:**	_____ / _____ / _____
Address:				**Hire Date:**	_____ / _____ / _____
City:		**State:**	**Zip:**	**Hours:**	_____hours per week
Phone:	( )	**Marital Status:**	**Date of Marriage:**	**Gender:**	❑ Male ❑ Female

Name of Enrolling Dependent(s)	**Birth Date**	**Relationship to Employee**	**Gender**	**SSN**	**Election**	
					Medical	**Dental**
1)		❑Spouse ❑Child ❑Domestic Partner	❑Male ❑Female		❑ Add ❑ Delete	❑ Add ❑ Delete
2)		❑Child	❑Male ❑Female		❑ Add ❑ Delete	❑ Add ❑ Delete
3)		❑Child	❑Male ❑Female		❑ Add ❑ Delete	❑ Add ❑ Delete
4)		❑Child	❑Male ❑Female		❑ Add ❑ Delete	❑ Add ❑ Delete
5)		❑Child	❑Male ❑Female		❑ Add ❑ Delete	❑ Add ❑ Delete
6)		❑Child	❑Male ❑Female		❑ Add ❑ Delete	❑ Add ❑ Delete

Current Coverage, Prior Coverage and **Coordination of Benefits:** If you or any dependent currently has or has had other group medical coverage (including Medicare) within the last 3 calendar months, please complete below.

Name of Family Member	**Other Employer (or Medicare)**	**Date Coverage Began**	**Date Coverage Ended**	**Insurance Carrier**	**Group Number**

***Waiving Coverage:** Complete this section if coverage is being declined by you or your eligible dependents

Name of Waiving Member	**Declining Coverage Reason**			
	☐ Other group coverage through this employer	☐ Other group coverage through another group (e.g., spouse's employer)	☐ Individual Coverage	☐ Medicare, Medicaid, Tricare
	☐ Other group coverage through this employer	☐ Other group coverage through another group (e.g., spouse's employer)	☐ Individual Coverage	☐ Medicare, Medicaid, Tricare
	☐ Other group coverage through this employer	☐ Other group coverage through another group (e.g., spouse's employer)	☐ Individual Coverage	☐ Medicare, Medicaid, Tricare

By signing below, I acknowledge that I have read, understand and agree to the Terms & Conditions on all pages of this application.

Employee Signature	**Date**

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Terms & Conditions

Application Agreement

I hereby apply for coverage under the contract between the issuer and my employer or group, and I agree with the terms of the contract. I also apply for the same coverage for my spouse and/or my children listed on this application. I attest that my listed dependents and I meet all the eligibility criteria set forth in the outline of benefits and/or the contract.

I agree to pay in advance the appropriate rates for myself and listed dependents and authorize rate increases as the company deems necessary.

Anti-Fraud Statement

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. I have provided these answers as part of the application procedure required by the issuer to enroll in coverage and I attest that all information completed on this application is true, correct, and complete. I understand that the issuer will rely on each answer in making coverage and rating determinations.

Health Privacy - Release of Information

I acknowledge and understand my health plan may request or disclose health information about me or my dependents (persons who are eligible for benefits coverage and are listed on the enrollment application) 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: a physician, dentist, pharmacist or other physical or behavioral health care practitioner; a clinic, hospital, long term care or other medical facility; any other institution providing care treatment, consultation, pharmaceuticals or supplies; or 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. A copy of the NATA Health Plan's Notice of Privacy Practice and the Medical, Dental Vision insurers Notice of Privacy Practices is available upon request.

Medical and Vision Insurance Benefits are underwritten by:
Health Net Health Plan of Oregon, Inc.; 13221 SW 68th Parkway Suite 200, Tigard, OR 97223-8328
Kaiser Foundation Health Plan of the Northwest; 500 N.E. Multnomah Street Suite 100, Portland, OR 97232-2099
Dental Insurance Benefits are underwritten by:
Regence BlueCross BlueShield of Oregon; P.O. Box 1271 MS WW2-25, Portland, OR 97207-1271
LifeMap Assurance Company; 100 Southwest Market Street, Portland, OR 97201

*Administered by **Benefit Solutions, Inc.***

Physical address:
12121 Harbour Reach Drive, Suite 105
Mukilteo, WA 98275

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