

CHECK HERE IF THIS IS A CHANGE OF HEALTH PLAN ENTIRE FORM MUST BE COMPLETED

**HANFORD EMPLOYEE WELFARE TRUST (HEWT) MEDICAL/DENTAL ENROLLMENT FORM**

EFFECTIVE DATE: \_\_\_\_\_

LAST NAME \_\_\_\_\_ FIRST NAME \_\_\_\_\_ M.I. \_\_\_\_\_ PR NO. \_\_\_\_\_ SSN \_\_\_\_\_ BIRTHDATE (M/D/Y) \_\_\_\_\_

MAILING ADDRESS \_\_\_\_\_ MSIN \_\_\_\_\_ HOME PHONE ( ) \_\_\_\_\_ WORK PHONE ( ) \_\_\_\_\_

CITY, STATE, ZIP \_\_\_\_\_

CHECK ONE:  ACTIVE  RETIRED  LTD  COBRA  OTHER: \_\_\_\_\_

COMPANY:  FH  CH2M  NHC  EnergySolutions  JCI  ENW  Parsons  ATL  \_\_\_\_\_

**ACTIVE EMPLOYEE MEDICAL PLAN:**  United Healthcare PPO-N  Group Health Options Point-of-Service

**RETIREE MEDICAL PLAN:**  UnitedHealthcare  Group Health Options Point-of-Service

LEVEL OF COVERAGE:  Waive Coverage  Self Only  Self + One  Self + More Than One

Covered Under HEWT Spouse?  Yes  No Spouse SSN \_\_\_\_\_

**ACTIVE EMPLOYEE DENTAL PLAN:**  HAMTC/HGU  NON-BARGAINING/OPEIU  ALL EMPLOYEES

CIGNA Dental Assistance  Washington Dental Core  Willamette Dental - WA  CIGNA Dental Plus  Washington Dental Buy-Up

LEVEL OF COVERAGE:  Self Only  Self + One  Self + More Than One

Covered under HEWT Spouse?  Yes  No Spouse SSN \_\_\_\_\_

LAST NAME	FIRST NAME	M.I.	SEX W/F	SOCIAL SECURITY NUMBER	BIRTHDATE (M/D/Y)	MED (X)	DENT (X)	RELATIONSHIP	COLLEGE STUDENT DISABLED
SPOUSE									
CHILD (LEGAL LAST NAME)									S D
CHILD (LEGAL LAST NAME)									
CHILD (LEGAL LAST NAME)									
CHILD (LEGAL LAST NAME)									

WILL YOU OR ANY OTHER PERSON NAMED ABOVE BE COVERED BY OTHER HEALTH INSURANCE OR MEDICARE?  YES  NO

THE OTHER INSURANCE IS:  GROUP COVERAGE  INDIVIDUAL COVERAGE  MEDICARE PART-A\*  MEDICARE PART-B\*  MEDICARE PART-D

I hereby apply for enrollment in the plan(s) identified above and authorize my employer to deduct from my earnings the necessary contribution(s), if any, required of me. I understand that services for which I (we) am eligible must be obtained in accordance with the terms of my benefits plan. I hereby authorize any physician, insurer, or other organization or person having any records, data, or information concerning my health history or other insurance for me or my minor dependents, to furnish such records, data, or information as may be requested by the health plan identified above or their duly authorized representative. A copy of this authorization shall be considered as effective and valid as the original. I understand that I must enroll myself and/or dependents in a health plan within 31 days of becoming eligible, or I must wait for the next regular open enrollment period. I understand contributions are subject to change.

YOUR SIGNATURE **X**

DATE: \_\_\_\_\_