



# WEA SELECT ENROLLMENT AND CHANGE APPLICATION



**Part 1. Employee Information**

**School District Name:** \_\_\_\_\_

Employee Name (Last, First, MI) \_\_\_\_\_

Home Address – Street and Number \_\_\_\_\_ Home Phone ( ) \_\_\_\_\_ Work Phone ( ) \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_ Social Security No. \_\_\_\_\_ Date of Birth / / \_\_\_\_\_

**Other Coverage Information:** Will you or any eligible family member enrolled on your WEA Select Plan have any other active medical, vision, or Medicare coverage (**other than applied for below**) at the time this coverage begins?  Yes  No

**Part 2. WEA Select Medical Plan Selection and Enrollment**  
**Note:** Not all School Districts or employee groups offer all WEA Select Medical Plans

Waive Medical  WEA Plan 1  WEA Plan 2  WEA Plan 3  WEA Plan 4-500  WEA Plan 4-750  WEA Plan 5

**Please list ALL enrollees to be covered, added or dropped on your medical plan**

Relationship	Keep	Add	Drop	Name (Last, First, MI)	Social Security No.	Gender M / F	Birth Date Mo / Day / Yr	Disabled
Self	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				/ /	N/A
Spouse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				/ /	N/A
Child	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				/ /	<input type="checkbox"/> Yes
Child	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				/ /	<input type="checkbox"/> Yes
Child	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				/ /	<input type="checkbox"/> Yes

**Part 3. WEA Select Vision Plan Selection and Enrollment**  
**Note:** Not all School Districts or employee groups offer WEA Select Vision Plans

No WEA Vision  WEA Plan A  WEA Plan B  WEA Plan C  WEA Plan D  WEA Plan E  WEA Plan F

**Please list ALL enrollees to be covered, added or dropped on your vision plan**

Relationship	Keep	Add	Drop	Name (Last, First, MI)	Social Security No.	Gender M / F	Birth Date Mo / Day / Yr	Disabled
Self	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				/ /	N/A
Spouse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				/ /	N/A
Child	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				/ /	<input type="checkbox"/> Yes
Child	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				/ /	<input type="checkbox"/> Yes
Child	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				/ /	<input type="checkbox"/> Yes

In applying for enrollment as indicated on this application, I declare that to the best of my knowledge, all of the information on this form is true and complete, and all of the persons for whom I am requesting enrollment are eligible for coverage. I understand that 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. The changes on this form supersede all previous forms submitted. I authorize my employer to deduct from my earnings the amount, if any, for the coverage selected.

**Please read important Privacy Information on the back of this form**

**X** \_\_\_\_\_  
**Employee Signature** (Please keep goldenrod copy for your records)

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
**Date Signed**

**Part 4. To be Completed by School District**

Effective Date of Insurance	Date Eligible For Insurance
/ /	/ /

**Check Appropriate Enrollment Box and Provide Date:**  New Employee  Insurance Eligible  Open Enrollment  Dependent Change

**Change of Status:**  Marriage/Domestic Partnership  Divorce  Death  Surviving Dependents  Birth  Special Enrollment  
 Adoption\*  Medical Child Support Order\*  Legal Guardianship/Non-parental Custody\*

\* Legal Documentation Required **Date of Qualifying Event:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Loss of Other Coverage – Reason** \_\_\_\_\_ **Date Prior Coverage Ended:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Employer:** Send white and yellow copies to Premera Blue Cross; retain pink copy for your records.

**Premera Blue Cross Use:** ID Number: \_\_\_\_\_ ID Card  Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Initials: \_\_\_\_\_

## **NOTICE OF INFORMATION USE AND DISCLOSURE**

When you apply for or are enrolled on this health plan, we may collect, use, share or disclose Protected Personal Information (PPI). PPI includes information about your health, including medical records, information on prior or current health-care coverage, and personal information such as your address, telephone number, and Social Security Number. This information may come from health-care providers, insurance companies (including corporate affiliates of Premera Blue Cross) or other sources.

We may collect, use, or disclose your PPI to conduct routine business functions, such as:

- Determining your eligibility for enrollment, credit for waiting periods, benefits;
- Paying claims and coordinating benefits with other insurers;
- Conducting case and care management, and quality reviews;
- Fulfilling other legal obligations specified in our contract with you; and,
- We may also collect or disclose PPI as required or permitted by law.

If a disclosure of PPI is not related to a routine business function, we remove anything that can be used to easily identify you, or we obtain your prior signed authorization. This authorization will describe the PPI to be released, who it is released to, reasons for the release, and the time period in which the authorization is valid. You may revoke this authorization.