MACHINISTS HEALTH AND WELFARE TRUST FUND

PLEASE PRINT

ENROLLMENT FORM

ALASKA F21

☐ New Participant ☐ Address Change ☐ Add Dependent(s) ☐ Remove Dependent(s) ☐ Change Beneficiary
Indicate qualifying event when adding a dependent outside of open enrollment. Birth/Marriage/Adoption/Loss of coverage/Other (Circle one)

Employer: | Date of Hire:

Indicate your health coverage election. Medical benefits are underwritten by the following healthcare insurance carrier.
SEND COMPLETED APPLICATIONS TO WPAS, PO BOX 34203 SEATTLE 98124
Alaska Members: Regence BlueShield; 1800 Ninth Avenue; PO Box 21267; Seattle, WA 98111-3267

NAME (Last, First, MI)	**SOCIAL SECURITY or WPAS IDENTIFICATION NUMBER**	**SEX**	**BIRTHDATE** (Mo/Day/Year)	**RELATIONSHIP TO EMPLOYEE**	**PHONE NUMBER**
Employee				**Self**	
Mailing Address (Street or PO Box, City, State, Zip Code)					
Spouse/Domestic Partner				**Spouse/Domestic Partner**	**Check if Step, Foster or Adopted Child**
Dependent Children					

☐ **Single** ☐ **Married** ☐ **Divorced** **If Married, date of Marriage:** **If Divorced, date of Divorce:**

Do you or any of your dependents applying for coverage have other coverage with any health care plan including Medicare? ☐ Yes ☐ No If you have Medicare, you must submit a copy of your Medicare ID card to the Administration Office. If you have coverage through any health care plan, you must complete the following information

Name of Participant with Other Coverage | Social Security Number | Policy or I.D. Number

Name and Address of Insurance Company (or Medicare) | City | State | Zip

1. Insurance covers: Subscriber Spouse/Domestic Partner Children
*Date Coverage Began _____ *Date coverage ended_____
2. If divorced or separated, please provide full name of parent with custody:_____
3. If divorced, did the court establish financial responsibility for the child(ren)'s health care? ☐ Yes ☐ No
If "yes", please specify the name and address of the person with responsibility:_____

BENEFICIARY DESIGNATION - LIFE INSURANCE (DEATH BENEFITS)

NAME (Last, First, Middle Initial)	**SOCIAL SECURITY NUMBER**	**BIRTHDATE (Mo/Day/Year)**	**RELATIONSHIP TO EMPLOYEE**	**BENEFIT**
				%
				%
				%

Unless otherwise noted, if 2 or more beneficiaries are named, the proceeds shall be paid in equal shares to the named beneficiaries surviving the insured.

I hereby verify that all of the information provided above is accurate and complete. I have also read and understood the Release of Information provisions on the reverse side of this application.

Signature ***(must be signed by participating member)*** Date

RETURN A COPY TO THE ADMINISTRATION OFFICE: WPAS, Inc., P.O. BOX 34203 · SEATTLE, WA 98124-1203

APPLICATION AGREEMENT

I hereby apply for coverage under the contract between Regence BlueShield, which is an independent licensee of the Blue Cross and Blue Shield Association, 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 dependent children listed on this application. I certify that my listed dependents and I meet the eligibility criteria set forth in the outline of benefits and/or the contract.

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

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 form) 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.

*For more information about such uses and disclosures, including uses and disclosures required by law, please refer to the Regence Consumer Privacy Notice. A copy is available from our web site (www.wa.regence.com) or by phone at 1-800-458-3523 or in Seattle (206) 464-3663 or write to Regence BlueShield, 1800 Ninth Avenue, PO Box 21267, Seattle, Washington 98111-3267.