PLU Medical, Dental, Basic Life & AD&D Application

PLU's Group Plan Offerings, Carriers and their Addresses		*Active*	*Retiree*
Kaiser Foundation Health Plan of Washington Options, Inc. **Access PPO Plan**		**6498700**	**6498800**
Kaiser Foundation Health Plan of Washington **Virtual Plus Plan**		**2342500**	**2342600**
Kaiser Foundation Health Plan of Washington **HSA Plan**	*Individual*	**1658400**	**1658900**
2715 Naches Ave. SW, Renton, WA 98057	*Family*	**1658500**	**1659000**
Delta Dental of Washington 400 Fairview Ave. N., Suite 800, Seattle, WA 98109-5371		**287**	
Willamette Dental of Washington Inc. 6950 NE Campus Way, Hillsboro, OR 97124-5611		**WA137**	
Unum Insurance Company 2211 Congress St., Portland, ME 04122-0002		**801770 / 801771**	

HR Use *ONLY:*
- ☐ Medical
- ☐ Dental
- ☐ PDABCOV
- ☐ Waive
- ☐ Hourly
- ☐ Salaried

Section A. PURPOSE OF APPLICATION:

☐ New Employee ☐ Open Enrollment ☐ New Enrollee (current employee) ☐ Change of Beneficiaries ***Skip sections C- D***

☐ Drop ☐ Add Dependent(s); *Name(s)*_____ ☐ Medical ☐ Dental

☐ Waive/Terminate Employee & Dependent(s) ☐ Medical ☐ Dental (If both, ***Skip section C***)

Effective Date:

HR Notes:

Section B. BASIC EMPLOYEE INFORMATION:

Last Name, First Name, MI	PLU ID #:	Birthdate	Phone:	Date of Hire:
Street Address: City, State, Zip	Department:	Work Phone:	Gender ☐ Female ☐ Male	Status: ☐ Active ☐ Retiree

Section C. BENEFIT ELECTIONS FOR YOURSELF AND YOUR ENROLLED DEPENDENTS

Employee section: ***This section must be completed at all times unless specified otherwise***

Medical/Vision	HR Use *ONLY*	**Dental**
Choose one: ☐ Access PPO ☐ Virtual Plus ☐ HSA	☐ HSA Form	***Choose one:*** ☐ Delta Dental of WA ☐ willamette Dental of WA

NOTE: *You may elect to enroll yourself only (above) or include some or all of your eligible family members (below) on your plan(s). This could include children of domestic partners. All members enrolling will have the same medical and dental plan as you the employee elects. The Medical and Dental plans are independent, each enrollee has the option to have* ***medical only*** *or* ***dental only*** *or* ***both***

I certify that neither myself nor my spouse/domestic partner will be enrolled in other group/employer provided coverage while enrolled on PLU's medical and/or dental plan. ☐ **Yes** ☐ **No**

Enrolled Dependents Last Name	First Name	MI	Relationship, e.g. Spouse,	Social Security Number	Gender	Birthdate	Medical/Vision (Yes or No)		Dental (Yes or No)	
							☐ Yes	☐ No	☐ Yes	☐ No
							☐ Yes	☐ No	☐ Yes	☐ No
							☐ Yes	☐ No	☐ Yes	☐ No
							☐ Yes	☐ No	☐ Yes	☐ No
							☐ Yes	☐ No	☐ Yes	☐ No
							☐ Yes	☐ No	☐ Yes	☐ No

Copies: Medical Dental HR Employee *(over)*

Questions? Contact Human Resources, Aileen Ochinang at 253-535-8146 or ochinaav@plu.edu

Section D. WAIVER OF COVERAGE

If you have other insurance and you want to *decline* the medical or dental insurance:

You must have medical and/or dental coverage elsewhere in order to decline employee only coverage with PLU. I am currently covered under another medical and/or dental plan. Therefore, I decline ☐ Medical and/or ☐ Dental for myself. I do not want to enroll, even though PLU pays the majority of the employee premium for the base medical and dental plans. I understand that if I change my mind, I may not be able to enroll on the medical or dental plan until the next open enrollment period.

Signature of Employee:	Date:	Name of Medical Carrier:	Name of Dental Carrier:

Section E. GROUP TERM LIFE AND AD&D INSURANCE - BENEFICIARIES

This is a PLU paid insurance coverage (refer to benefits summary). This section must be completed at all times. You may write down "see previous form" only if applicable.

You may list one or more beneficiaries. If listing multiple beneficiaries, please indicate the percentage of the benefits each is to receive, which must total 100%.

Primary Beneficiary:	Relationship:	%	Primary Beneficiary:	Relationship	%
Secondary Beneficiary:	Relationship:	%	Secondary Beneficiary:	Relationship	%

Section F. IMPORTANT INFORMATION YOU NEED TO KNOW

Please read this section and sign the bottom of this form to certify its content and complete the enrollment process:

- This application may include my spouse/state registered domestic partner or non-registered domestic partner, as recognized by PLU and/or Washington State and confirmed on PLU's Affidavit of Domestic Partner-Marriage Form. Washington State Registered Domestic Partners are treated the same as a spouse.
- I authorize any insurance company, health plan, employer, hospital or physician to release all information with respect to me or my dependents that has a bearing on these benefits provided by PLU.
- I authorize PLU to reduce my salary in the amount necessary to pay for the coverages shown above. Such reductions are considered elective contributions under the PLU Reimbursement Plan. I understand that these salary reductions may not be revoked or changed during the Plan Year except following a change in my family status as defined by the IRS, including things like my marriage or divorce, death, the birth or adoption (based on the date of assumption of a legal obligation for total or partial support) of a child, the termination or commencement of employment of my spouse or domestic partner, or the taking of an unpaid leave of absence by me or my spouse or domestic partner.
- I further authorize PLU to continue this election, and to make future adjustments in the amount of the salary reduction if the cost of coverage in any program selected changes if I do not file a new election form.
- If the cost of my share of the premiums for the plan and dependent enrollment I elect exceeds my salary, I agree to pay PLU directly according to PLU's payment policy.
- I understand that I am financially responsible for charges involving benefits and services that are not covered in whole or part by PLU's Carriers.
- I understand that dependent children are covered to age 26; regardless of student status.
- I certify that the information here is correct to the best of my knowledge. 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 (RCW 48.135.080).

Signature of Employee: **Date:** **Group Administrator's Signature:** **Date:**

PLEASE COMPLETE (IN FULL) BOTH SIDES OF THIS FORM, ENROLLMENT CAN NOT BE PROCESSED IF THE APPLICATION IS SUBMITTED INCOMPLETE.

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