Parametrix

Healthcare Enrollment & Change Form

This form supersedes all other forms. Please PRINT CLEARLY in blue or black ink.

EMPLOYEE INFORMATION (to be completed Parametrix): **Date of Hire/Rehire:____________ Effective Date:_________ Annual Salary:_________ Hours per Week:_______**
HR Authorization:_______ Employee ID #:________ Location: ______________

Type of Form: ☐ New Enrollment ☐ Change Existing Enrollment ☐ Other: _______________

Type of Change: ☐ Address ☐ Name Change ☐ New Marriage/Date of Marriage: _______ ☐ Beneficiary

Add/Delete: ☐ Child(ren) ☐ Spouse ☐ Domestic Partner (DP)*

Social Security: **Full Name (First, MI, Last):**

Home Address: ☐ **Updated Address**

City: **State:** **Zip:**

Home Phone: **Birth Date:** ☐ **Male** ☐ **Female** ☐ **Single** ☐ **Married** **Occupation:**

Email Address:

PLEASE CHECK YOUR SELECTION BELOW. OFFERED BY: **PREMERA BLUE CROSS** 7001 220TH STREET SOUTHWEST, MOUNTLAKE TERRACE, WA 98043 GROUP #**1037345**

Medical/Vision/RX
Choose Plan:
☐ PPO Plan
☐ High Deductible Health Plan (HDHP)*

Choose Enrollment:
☐ Employee Only
☐ Employee & Spouse or Domestic Partner
☐ Employee & Child(ren)
☐ Employee & Family

☐ Waive
(If waiving, please complete the opt out section on the back of this form.)

Dental
Choose Enrollment:
☐ Employee ☐ Employee & Spouse or Domestic Partner ☐ Employee & Child(ren) ☐ Employee & Family

☐ Waive

***HEALTH SAVINGS ACCOUNT (HSA) –**Only individuals enrolled in HDHP may contribute to an HSA.
Important: HSA account holders must manage contributions per IRS regulations.
2022 maximum plan year contribution is $3,850/individual or $7,750/family. Participants age 55 and older may contribute an additional $1,000 “catch-up” amount. Your contribution will be deposited in your HSA bank account. Please note: These limits include the Parametrix HSA contribution.

☐ I elect to contribute payments of $______ each pay period via payroll deduction beginning the next available paycheck. Note: Pay period contribution elections will continue unchanged from year-to-year unless you contact benefits@parametrix.com to request a change. Election changes may be made at any time.

DEPENDENT INFORMATION – Must be completed for all enrolled dependents. (Use additional forms to list additional dependents) ***Dependent children may be covered up to age 26.**

Soc. Sec. Number	Relationship to Employee	Full Name (First, MI, Last)	Sex	Birth Date	Medical/Vision/RX	Dental
	☐ Spouse ☐ DP		☐ M ☐ F		☐ Add ☐ Drop	☐ Add ☐ Drop
	Child(ren)		☐ M ☐ F		☐ Add ☐ Drop	☐ Add ☐ Drop
	Child(ren)		☐ M ☐ F		☐ Add ☐ Drop	☐ Add ☐ Drop
	Child(ren)		☐ M ☐ F		☐ Add ☐ Drop	☐ Add ☐ Drop
	Child(ren)		☐ M ☐ F		☐ Add ☐ Drop	☐ Add ☐ Drop

PLEASE SIGN ON THE BACK SIDE OF THIS PAGE FOR COVERAGE TO TAKE EFFECT

IF YOU ARE CHOOSING TO OPT OUT: ***Date of Opting Out:*** ***Proof of Opting Out:***

Which Plan Are You Opting Out: ☐ Medical/Vision/Rx ☐ Dental ☐ Both:

OPTING OUT AGREEMENT ***Please initial after each statement***

- I am choosing to opt out of the Parametrix plan noted above for myself and my family. Life/AD&D, Short/Long-Term Disability and the EAP plans will remain in place and the premiums for these plans will be paid for by Parametrix. __________
- I understand that if at a later date I experience a qualifying event (marriage, divorce, birth or adoption of a child, or my spouse gains or loses healthcare coverage; other events may qualify as well, please see the plan administrator for full list), I have 30 days to opt back into the healthcare coverage. __________
- I understand that I will recieve $100 added to my paycheck for each pay period (not to exceed 24 additions in a given year) for electing the opt out provision. __________
- I understand that this $100 benefit will be taxed based on my current tax elections. __________
- **Important**: In addition, by opting out of the Parametrix healthcare plan, I am stating that at the time of opting out, I have other creditable and active healthcare coverage in place. Proof of this coverage (current healthcare insurance card) must be presented before I will be approved for the opt out provision. __________
- I will have the opportunity to opt back into the plan each year during open enrollment. __________

OTHER HEALTHCARE COVERAGE ***Please list your current, valid healthcare insurance policy***

Type of coverage: ☐ Medical ☐ Dental ☐ Vision

Name and Address of Insurer: ____________________ Date Coverage Began: ____________________

Name of Policy Holder: ____________________ Birth Date: ____________________

If you have Medicare, what was beginning date for Part A:__________ Part B: __________ Medicare HIC No. with Alpha Suffix:__________

☒ **Life/AD&D/STD/LTD Group** #218930
Offered by: **UNUM Life Insurance Company of America**
2211 Congress Street, Portland, ME 04122

☒ **EAP**
Offered by: **LifeWorks**
201 17th Street NW, Suite 630, Atlanta, GA 30363

LIFE INSURANCE BENEFICIARY	**Name**	**Relationship**	**Social Security Number**	**Percent**	**Address**
Primary Beneficiary:					
Secondary Beneficiary:					

RELEASE AND AUTHORIZATION:

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 healthcare treatment, payment or for the purpose of business operations necessary to administer healthcare 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).

ANTI-FRAUD STATEMENT:

I understand 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.

EMPLOYEE SIGNATURE:______________________________ **DATE:**______________