Parametrix

Healthcare Open Enrollment & Change Form - COBRA

This form supersedes all other forms. Please PRINT CLEARLY

EMPLOYEE INFORMATION (to be completed by Parametrix):

Date of Termination:_____ **HR Authorization:**_____ **Employee #:**_____ **Location:**_____

Transfer to COBRA: Start Date: _____ ☐ 18 Months ☐ 36 Months ☐ Change Existing Enrollment ☐ Other: _____

Type of Change: ☐ Address ☐ Name Change ☐ New Marriage/Date of Marriage: _____

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

Social Security:	**Full Name (First, MI, Last):**			
Home Address:				☐ **Updated Address**
City:		**State:**		**Zip:**
Home Phone:	**Birth Date:**	☐ **Male** ☐ **Female**	☐ **Married** ☐ **Single**	**Occupation:**

PLEASE CHECK YOUR SELECTION BELOW

☐ **Medical/Vision/RX** Group #1037345 *Offererd by:* **Premera Blue Cross** 7001 220th Street Southwest Mountlake Terrace, WA 98043	**Choose Plan:** ☐ PPO Plan ☐ High Deductible Health Plan (HDHP)	**Choose Enrollment:** ☐ Employee Only ☐ Employee & Spouse or Domestic Partner ☐ Employee & Child(ren) ☐ Employee & Family
☐ **Dental** Group #1037345 *Offered by:* **Premera Blue Cross** 7001 220th Street Southwest Mountlake Terrace, WA 98043		**Choose Enrollment:** ☐ Employee Only ☐ Employee & Spouse or Domestic Partner ☐ Employee & Child(ren) ☐ Employee & Family
☐ **Employee Assistance Program (EAP)** *Offered by:* **LifeWorks** 201 17th Street NW, Suite 630 Atlanta, GA 30363		**Choose Enrollment:** ☐ Employee Only ☐ Employee & Spouse or Domestic Partner ☐ Employee & Child(ren) ☐ Employee & Family

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

DEPENDENT INFORMATION – Must be completed for all enrolled dependents. (Use additional forms to list additional dependents)					
Soc. Sec. Number		**Full Name (First, MI, Last)**	**Sex**	**Birth Date**	**Place X in Box**
	☐ **Spouse** ☐ **DP***		☐ **M** ☐ **F**		☐ Add ☐ Drop
	Child(ren)**		☐ **M** ☐ **F**		☐ Add ☐ Drop
	Child(ren)		☐ **M** ☐ **F**		☐ Add ☐ Drop
	Child(ren)		☐ **M** ☐ **F**		☐ Add ☐ Drop
	Child(ren)		☐ **M** ☐ **F**		☐ Add ☐ Drop
	Child(ren)		☐ **M** ☐ **F**		☐ Add ☐ Drop
	Child(ren)		☐ **M** ☐ **F**		☐ Add ☐ Drop

***Please note: Includes both registered and non-registered domestic partners.** ***Dependent children may be covered up to age 26.**

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).

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:**