



WEA SELECT ENROLLMENT AND CHANGE APPLICATION



School District Name: New Enrollment Change Enrollment

Employee Information
Employee Name (Last) _____ (First) _____ (MI) _____ Home Phone (____) _____ Work Phone (____) _____
Social Security No. _____ Birth Date (MM/DD/YYYY) _____

Home Address—Street and Number _____ City _____ State _____ ZIP _____

Mailing Address (if different from home address) _____

Will you or your dependent(s) enrolled on your WEA Select Plan have any other active medical, vision, or Medicare coverage when this coverage begins?
 No Yes, please complete and attach an **Other Coverage Questionnaire** form.

Is any child over the dependent age limit applying for coverage due to a disability? No Yes, please complete and attach the **Request for Certification of Disabled Dependent** form.

Medical and Vision Plan Selection and Enrollment (Not all districts or employer groups offer all plans. PLEASE See Enrollment Notes on the reverse side)
 Waive WEA Medical WEA Plan 1 WEA Plan 2 WEA Plan 3 WEA Plan 5 WEA EC-A WEA EC-B WEA EC-C
 No WEA Vision Vision Plan A Vision Plan B Vision Plan C Vision Plan D Vision Plan E Vision Plan F

Relationship to Employee	Name (26 characters maximum, including spaces). Last, First, Middle Initial Note: Names on ID cards are limited to 26 characters and spaces Example: Harrison Michelle T	Social Security No. (same as above)	Gender M / F	Birth Date (Mo., Day, Yr.) (same as above)	Please check applicable boxes										
					WEA Medical	Keep	Add	Drop	WEA Vision	Keep	Add	Drop			
Spouse/DP:	— SELF —		<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child:			<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child:			<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child:			<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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 have also read and understand the provisions as stated on the reverse side. 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.
If filling out the online form, please print two copies of the application—one for your records and one for the school district. If filling out the 4-part form, keep goldenrod copy and return the others to the district.
Be sure to sign your application before turning it in.

Employee Signature: **X** **Date Signed:** _____

Note: 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.

To be completed by School District Please print a copy for your records if using the online form. Or, send white & yellow copies to Premera; retain pink copy for your records.
Check Appropriate Enrollment Box and Provide Date:
 New Employee Insurance Eligible Open Enrollment Dependent Change
 Discount rate Full rate Change of Status: Marriage/Domestic Partnership Divorce Death Surviving Dependents Birth Special Enrollment
Legal documentation is attached for: Adoption Medical Child Support Order Legal Guardianship/Non-parental Custody
Date of Qualifying Event: ____/____/____ **Loss of Other Coverage—Reason:** _____ **Date Prior Coverage Ended:** ____/____/____

Check Eligible For Insurance _____ **Effective Date of Insurance** _____
Check Appropriate Enrollment Box and Provide Date: _____ **Effective Date of Insurance** _____

Premiera Blue Cross Use Only ID Number: _____ ID Card: _____ Date: ____/____/____ Initials: _____