2018 - OAK HARBOR FREIGHT LINES
EMPLOYEE HEALTH CARE ENROLLMENT FORM
Group Number: 020189

For RGA Use Only
In System ___________
To PCS ___________
Elig. Rep. Initials ___________

☐ New Enrollee ☐ Open Enrollment ☐ Name Change ☐ Address Change

☐ Add Spouse/Dependent Reason: ____________________

If Adding Spouse, Date of Marriage: ____________________
(If adding dependent(s) due to adoption, court order, or legal guardianship, you must provide legal documentation.)

REQUIRED: ☐ **Employee File #**____________________ ☐ **Hire Date**: ____________________

Soc. Sec. # ____________________ **Date of Birth** ____/____/____ **Sex**: ☐ M ☐ F **Telephone Number** (______)______________

Participant Last Name ____________________ **First Name** ____________________ **M.I.** __________

Mailing Address ____________________ **City** ______________ **State** __________ **Zip Code** ____________

I elect the following plan (please select only one):

☐ **Base Health Plan** ☐ **High Deductible Health Plan**

Check here if electing to waive all coverage ☐

List below all dependents (Spouse/Children) you wish to cover: (sex, date of birth, and social security number required)

First Name	M.I.	Last Name	Sex	Date of Birth	Relationship D=Daughter S=Son	Social Security #

If dropping spouse/dependents please list name(s):

Name: ____________________ Term date: ___________ Reason: ____________________

Name: ____________________ Term date: ___________ Reason: ____________________

Prior Insurance Coverage Information

Have you had coverage prior to enrollment on this plan? ☐ Yes ☐ No
If yes, attach a copy of any Certificates of Creditable Coverage.

Type of coverage: ☐ Medical ☐ Dental ☐ Vision ☐ Other ____________________

List yourself and family member(s) who are listed above and were covered on your previous insurance plan. If effective or termination date for any family member is different than the employee’s, attach a Certificate of Creditable Coverage for that individual.

Disabled Dependent

List dependent who is developmentally disabled or physically handicapped who is over age 25:

Name: ___________________________ Medical documentation must be submitted within 31 days of the effective date of coverage.

Coordination of Benefits Information

Currently do you, your spouse or any of your children have coverage through another insurance plan? ☐ Yes ☐ No

If yes, please complete the following:

List yourself and family member(s) who are listed on this form and are currently covered through another plan.

Name of covered members:	**Type of Coverage:** (M)edical (D)ental (V)ision	**Type of Policy:** (G)roup (I)ndividual	**Effective date** of coverage:	**Carrier Name:**
________________________________	__________	_________	___/___/__	_____________________________
________________________________	__________	_________	___/___/__	_____________________________

Provide the following information on the carriers listed above:

Carrier Name: ____ Policy Number: ____________________

Street Address: ____________________________________ City: _______________ State ________ Zip __________

Carrier phone #: ______________________

Subscriber's Name: ________________________ Social Security Number: ________________________ Date of birth:____________

Employer's Name and Address (if group coverage) ____

Certify that the above listed information is correct and that I am enrolling only eligible dependents as defined in the Plan Document. I understand that all entitlements to benefits are void, and coverage may be canceled or modified retroactively to its effective date, if I have made intentionally false or misleading statements or answers on behalf of myself or any family members. I authorize any person or institution providing care or services, or any organization in possession of insurance benefit information to release any and all information pertaining to the care or benefits provided to me or my dependents to Healthcare Management Administrators or its designated agent.

I acknowledge and understand that my health plan may request or disclose health information about me or my dependents (persons who are listed for benefits coverage on the enrollment form) from time to time 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: 1) A physician, dentist, pharmacist or other physical or behavioral health care practitioner; 2) A clinic, hospital, long term care or other medical facility; 3) Any other institution providing care, treatment, consultation, pharmaceuticals or supplies; or 4) 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 Privacy Notice. A copy is available upon request.

By signing below, I authorize OHFL to deduct pre-tax dollars from my paycheck each pay period for my share of the cost of health care insurance, when applicable.

Employee's Signature____ **Date Signed** _____/_____/____

EMPLOYER SECTION

Date Hired: ______/______/______ Seniority Date: ______/______/______ Coverage Effective Date: ______/____/____

Special Enrollment: ☐ Yes ☐ No If yes, what is the qualifying event? ____

Certified by: _________________ Today's Date: _____/____/_____ Location: __________________________________

Oak Harbor Freight Lines
Declaration For Dependent(s)
Health Care Coverage

Oak Harbor Freight Lines, Inc.
Corporate Office
P.O. Box 1469 • Auburn, Washington 98071-1469
1339 West Valley Hwy. • Auburn, Washington 98001
(253) 288-8300 • (800) 858-8815

This is an official declaration by an Oak Harbor Freight Lines employee regarding benefits governed by Pub.L. 93-406, 88 Stat. 829

Name: ______________________________ Employee Number: ____________

Dependents eligible for coverage under the Oak Harbor Freight Lines Health Care Plan are:

- An employee's legal spouse or when required by law, registered domestic partner.
- An employee's dependent child(ren) to age 26.
  - Dependent children are
    - any of the employee's natural children
    - legally adopted children
    - children who have been placed for adoption with the employee
    - step-children who depend on the employee for support
    - children who have been placed under the legal guardianship of employee by court decree
- An employee's unmarried dependent child(ren) who is incapable of self-support because of mental or physical incapacity.

To enroll a dependent or dependents onto your health insurance plan you will need to provide proof of the dependent's eligibility. Without proof of dependency, your dependents will not have health coverage through Oak Harbor Freight Lines. Proof of dependency can be accomplished only in the following manner:

- Spouse: A copy of marriage certificate (not marriage license)
- Child: A copy of the child's birth certificate.
- Step Children: A copy of marriage certificate (not marriage license)
- Adopted Child or Child under the Employee's Legal Guardianship: A copy of the adoption records or court decree.

I understand enrolling anyone into the Oak Harbor Freight Lines Health Care Plan who does not meet one of the above definitions is considered fraud. Any claims paid out on behalf of falsely enrolled dependents would be subject to reimbursement by me and would be grounds for termination of employment as this is considered falsification of employment records. Additionally, false statements may constitute insurance fraud punishable under state and/or federal law.

____
Initial Here

I understand it is my responsibility to un-enroll any dependent who no longer meets eligibility requirements.

____
Initial Here

I understand my dependents cannot be enrolled unless I have submitted the applicable proof of dependency as described below.

____
Initial Here

I declare under penalty of making a false statement that all dependents enrolled in the Oak Harbor Freight Lines health care plan under my name are qualified under one of the above definitions.

Employee Signature: ______________________________ Date: ______________________