Regence Group Administrators

Oak Harbor Freight Lines, Inc. EST. 1916

OAK HARBOR FREIGHT LINES

2019 EMPLOYEE HEALTH CARE ENROLLMENT FORM

Group Number: 020189

❑ **Open Enrollment** ❑ **New Enrollee** ❑ **Coverage Change** ❑ **Name Change** ❑ **Address Change**

❑ADD Spouse/Domestic Partner/Dependent Reason: _____ ❑ DROP Spouse/Domestic Partner/Dependent Reason: _____

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

❑ Rehire Date: ____/____/____ ❑Leave of Absence Date returned from LOA: ____/____/____

Hire Date: ____/____/____ **Employee #** _____

Soc. Sec. # _____ **Date of Birth** ____/____/____ **Sex**: ❑ M ❑ F **Telephone Number** (____) _____

Participant Last Name _____ **First Name** _____ **M.I.** _____

Mailing Address _____ **City** _____ **State** _____ **Zip Code** _____

Benefit Election Information

Plan Election (must select one option)

❑ Base Health Plan ❑ High Deductible Health Plan

Medical/Rx Election(s)	**Dental Election(s)**	**Vision Election(s)**
☐ Employee	☐ Employee	☐ Employee
☐ Employee & Spouse	☐ Employee & Spouse	☐ Employee & Spouse
☐ Employee & Children	☐ Employee & Children	☐ Employee & Children
☐ Employee & Family	☐ Employee & Family	☐ Employee & Family
☐ Waive	☐ Waive	☐ Waive

(NOTE: Your cost of benefits doesn't change whether you select all benefits or just one)

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

If dropping dependents please list name(s):

Name: _____ Termination date: _____ Reason: _____

Name: _____ Termination date: _____ Reason: _____

Disabled Child Eligibility

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

MUST be completed in order for your enrollment to be processed.

Note: Enrollment in the plan will not be processed if this enrollment form is submitted incomplete, including the applicant's signature and date signed. Notify the plan immediately of a change in address, or within 31 days of a change in status, over age dependent addition, or special enrollment opportunity, or within 60 days of a birth, adoption or placement for adoption

Coordination of Benefits Information

Is there anyone enrolling on the plan who currently has coverage through another insurance plan? ☐ Yes ☐ No

If yes, please complete the following:

Marital Status: ☐ Single ☐ Married_____ ☐ Widowed ☐ Legally Separated ☐ Divorced

Name of Spouse/Domestic Partner

If divorced, is there a court order for provision of the child? ☐ Yes ☐ No If yes, please attach a copy of the court decree. Per court decree:

Who has custody of child? _____ who provides insurance for child? _____

Please list the full name of the child (ren) _____

_____

Please list both the natural parents name and date of birth:

Natural Father _____ / DOB _____ Natural Mother _____ / DOB _____

List all family member(s), including yourself, who are included on this enrollment 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) _____

Is Employee, Spouse/Domestic Partner covered under this medical plan eligible for Medicare benefits? ☐ Yes ☐ No

If yes, enter date of eligibility for Medicare Part A _____date of eligibility for Medicare Part B _____

Social Security No._____

_____

I 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 from the Human Resources Department upon request.

Employee's Signature_____ **Date Signed** _____/_____/_____

By initialing 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.

_____**1% of gross wages for INDIVIDUAL coverage only** _____**2% of gross wages for FAMILY coverage**

EMPLOYER SECTION

Date Hired: _____/_____/_____ Seniority Date: _____/_____/_____ Coverage Effective Date: _____/_____/_____

Certified by: _____ Today's Date: _____/_____/_____ Terminal: _____

❑ **Deductions Entered in ADP**

Note: Enrollment in the plan will not be processed if this enrollment form is submitted incomplete, including the applicant's signature and date signed. Notify the plan immediately of a change in address, or within 31 days of a change in status, over age dependent addition, or special enrollment opportunity, or within 60 days of a birth, adoption or placement for adoption

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: _____