VIGILANT
Group Benefits Trust

Employee Enrollment Application, Cancellation, and Waiver

Effective Date of Enrollment, Termination or Change:		**Employer Name:**		**Medical Plan**	
		Employee Class:	❑Class 1 ❑Class 2 ❑Class 3	**Dental Plan**	

Check One ❑ New Enrollee ❑ Cancellation ❑ Name Change ❑ Add Dependents ❑ Delete Dependents ❑ Address Change
❑ Waiving ❑ COBRA ❑ Re-Hire [Date of Re-Hire_____]

Personal Information: (Please Print Clearly)

Employee Name:	Last:			**SSN:**	
	First:	M.I:		**Date of Birth:**	_____ / _____ / _____
Address:				**Hire Date:**	_____ / _____ / _____
City:		**State:**	**Zip Code:**	**Hours per week:**	
Phone:	( )	**Marital Status:**	**Date of Marriage:**	**Gender:**	❑ Male ❑ Female

Name of Enrolling Dependent(s)	Birth Date	Relationship to Employee	Sex	SSN	Election: Medical	Election: Dental
1)		❑Spouse ❑Child ❑Domestic Partner	❑Male ❑Female		❑ Add ❑ Delete	❑ Add ❑ Delete
2)		❑Child	❑Male ❑Female		❑ Add ❑ Delete	❑ Add ❑ Delete
3)		❑Child	❑Male ❑Female		❑ Add ❑ Delete	❑ Add ❑ Delete
4)		❑Child	❑Male ❑Female		❑ Add ❑ Delete	❑ Add ❑ Delete
5)		❑Child	❑Male ❑Female		❑ Add ❑ Delete	❑ Add ❑ Delete
6)		❑Child	❑Male ❑Female		❑ Add ❑ Delete	❑ Add ❑ Delete

Beneficiary for Optional Basic Life/AD&D Benefit

Name:		**Relationship:**	
Address:			

Current Coverage, Prior Coverage and **Coordination of Benefits:** If you or any dependent currently has or has had other group medical coverage (including Medicare) within the last three calendar months, please complete below.

Name of Family Member	Other Employer (or Medicare)	Date Coverage Began	Date Coverage Ended	Name of Insurance Carrier	Group Number

By signing below, I acknowledge that I have read, understand, and agree to the Terms & Conditions on all pages of this form.

Employee Signature	Date

VIGILANT
Group Benefits Trust

Employee Enrollment Application, Cancellation, and Waiver

Terms & Conditions

Application Agreement

I hereby apply for coverage under the contract between the issuer and my employer or group, and I agree with the terms of the contract. I also apply for the same coverage for my spouse and/or my children listed on this application. I certify that my listed dependents and I meet all the eligibility criteria set forth in the outline of benefits and/or the contract.

I agree to pay in advance the appropriate rates for myself and listed dependents and authorize rate increases as the company deems necessary.

Anti-Fraud Statement

It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. I have provided these answers as part of the application procedure required by the issuer to enroll in coverage and I certify that all information completed on this form is true, correct, and complete. I understand that the issuer will rely on each answer in making coverage and rating determinations. Penalties include imprisonment, fines, and denial of insurance benefits.

Release of Information

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 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 a physician, dentist, pharmacist or other health care practitioner, clinic, hospital, long term care or other medical facility; and 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).

Medical Coverage Underwritten by **Regence BlueCross BlueShield of Oregon;** 200 SW Market Street; Portland, OR 97201
Dental Coverage Underwritten by **Delta Dental of Washington;** 400 Fairview Avenue North, Suite 800, Seattle, WA 98109
Life and AD&D Insurance Benefits are underwritten by: **USAble Life;** P.O. Box 1650 Little Rock, AR 72223
Employee Assistance Program underwritten by: **UpriseHealth;** 2 Park Plaza, Ste 1200; Irvine, CA 92614
Vision Insurance Benefits are underwritten by: **VSP Vision Care, Inc. (HCSC);** 3333 Quality Drive; Rancho Cordova, CA 95670

*Administered by **Vimly Benefit Solutions***

Physical address:
12121 Harbour Reach Drive, Suite 105
Mukilteo, WA 98275

Mailing address:
PO Box 6
Mukilteo, WA 98275

Phone:
(425) 771-7359
(425) 367-0744

Fax:
(425) 771-1226

E-mail:
vgbt@vimly.com