

EMPLOYEE INFORMATION FORM

ASEA Health Trust

Address: 111 W. Cataldo, Suite 220, Spokane, WA 99201 • Phone: 866-553-8206 (toll-free); 509-328-0300 • Fax: 509-323-7614
Website: www.aseahealth.org

Use this form if you are a new employee or to notify the ASEA Health Trust Administrator of a change in your work status.

1. Complete this form.
2. Mail or fax it to the Administrator (address/fax number above). Or enroll online at www.aseahealth.org.
3. Submit this form to the Administrator within 30 days of hire or work status change.
4. Give your Departmental Personnel Office a copy of this form.
5. You will receive additional information in the mail.

It is your responsibility (not your employer, not your union) to personally contact the Health Trust to:

- Enroll in health benefits and/or optional benefit selections within 30 days of hire or work status change.
- Continue health coverage when you or your dependents are no longer eligible for coverage.

PLEASE PRINT CLEARLY (All sections must be completed)

Employee name:	SSN:	Employee ID:
Date of birth:	Gender: <input type="checkbox"/> M <input type="checkbox"/> F	Marital Status:
Mailing address:	<input type="checkbox"/> Check here if new address	
City/State/Zip:		
Work phone:	Home phone:	
Employer: <input type="checkbox"/> GGU <input type="checkbox"/> PSEA <input type="checkbox"/> City of Ketchikan <input type="checkbox"/> City of Fairbanks		

Select all of the following that describe you:

Full-time working 30+ hours weekly

- Long-term nonpermanent or permanent
 Seasonal

Part-time working 15–29 hours weekly

- Long-term nonpermanent or permanent part-time
 Seasonal

- Short-term nonpermanent, not eligible for health benefits

Select one:

If you are a new hire, the Health Trust will mail you a benefits enrollment packet when this form has been received.

- Turn in the enrollment form (in the packet) within 30 days of your hire date or work status change date.
- If you do not turn in an enrollment form, you will “default” to Plan A Full Family Coverage Health Plan, if you are a full-time employee. For part-time employees the default is no coverage.

<input type="checkbox"/> New hire	Hire date: _____	
<input type="checkbox"/> Work status change (select one) Effective date: _____	<input type="checkbox"/> Full-time to part-time <input type="checkbox"/> Part-time to full-time <input type="checkbox"/> Short-term nonpermanent to Long-term nonpermanent	<input type="checkbox"/> Return to work (note above does not apply) <input type="checkbox"/> Transfer from another bargaining unit to GGU
<input type="checkbox"/> Termination, leave, layoff or transfer (select one) Last day worked: _____	<input type="checkbox"/> SLWOP (Seasonal Leave Without Pay) <input type="checkbox"/> Layoff <input type="checkbox"/> Going to On-Call <input type="checkbox"/> Transfer from GGU to another bargaining unit	<input type="checkbox"/> LWOP (Leave Without Pay) <input type="checkbox"/> FMLA (Family or Medical Leave) <input type="checkbox"/> Separation from employment <input type="checkbox"/> Other

Please sign below to verify that the information you have provided is correct and that you understand it is your responsibility to contact the ASEA Health Trust regarding your health benefits.

Employee signature: _____

Date: _____