

FAMILY INFORMATION FORM

ASEA Health Benefits Trust

Address: PO Box 5434, Spokane, WA 99205 • Phone: 866-553-8206 (toll-free); 509-328-0300
Fax: 509-323-7614 • Website: www.aseahealth.org

Use this form to notify the ASEA Health Trust Administrator of a family status change (for example, marriage, divorce, or adding a dependent), or change in spouse employment, other health care coverage, or work status. Note: changes in work status must be reported to the Trust Administrative Office within five business days.

Reason for completing form:

- Marriage Divorce Adding dependent Name change Address change Work status change
 Other health care coverage

1. PERSONAL INFORMATION

Employee name: _____ SSN or Alternate ID: _____ Employee ID: _____
Mailing address: _____ Date of birth: _____
City/State/Zip: _____ Gender: M F Medicare ID: _____
E-mail: _____ Marital status: _____

2. SPOUSE INFORMATION (must be completed each year if you are enrolled in Plan A and cover your spouse)

Spouse's name: _____ SSN: _____ Date of birth: _____ Gender: M F

Please check one of the following:

a. Is your spouse currently employed? Yes No

b. Is your spouse eligible* for health benefits through his or her employer? Yes No

*Your spouse is considered eligible if his or her job position entitles them to be offered health benefits, even if your spouse declined coverage or failed to enroll timely.

c. Is your spouse enrolled in health benefits through his or her employer? Yes No*

If yes, provide the information about your spouse's coverage below.

*If your spouse is eligible for health coverage through his/her employer but did not enroll in that coverage, a **\$125 per month surcharge will be added to your payroll deduction.**

3. OTHER HEALTH CARE COVERAGE

I DO NOT have other health care coverage for myself, my spouse, and/or my other dependents.

I DO have other health care coverage (including Indian Health Services, Denali Kids, Medicare, or Medicaid) for myself, my spouse, and/or my other dependents, including (check all that apply):

Medical Prescription Dental Vision

Name of policyholder: _____ Policyholder date of birth: _____

Policy number: _____ Effective date: _____ Type of plan: Active Retiree

Insurance Company/Administrator: _____

Insurance Company/Administrator address: _____ Phone: _____

Please list all family members (including yourself) who are enrolled in this health plan: _____

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4. CHANGE IN FAMILY STATUS (add or remove spouse, add or remove child, name change)

- To add a spouse, you must provide a copy of the state-issued certificate of marriage.
- To remove a spouse, you must provide a copy of the state-issued divorce decree.
- To change a name, you must provide legal proof of the name change.
- To add dependent children, you must provide proof of age and custody for **each dependent child**, which means a copy of the birth certificate, adoption or foster care documents, or medical support orders (if applicable, i.e., divorce/custody).
- Enrollment for newborns must be accompanied by a hospital/doctor-issued birth certificate and followed up (within 90 days of birth date) with a copy of the state-certified birth certificate.

Dependent name:	Date of birth:
SSN:	<input type="checkbox"/> Add <input type="checkbox"/> Remove Effective Date:
Relationship: <input type="checkbox"/> Spouse <input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Stepson <input type="checkbox"/> Stepdaughter <input type="checkbox"/> Other:	

Dependent name:	Date of birth:
SSN:	<input type="checkbox"/> Add <input type="checkbox"/> Remove Effective Date:
Relationship: <input type="checkbox"/> Spouse <input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Stepson <input type="checkbox"/> Stepdaughter <input type="checkbox"/> Other:	

Complete additional "Dependent Information" pages as needed, if you have more than two dependents.

5. WORK STATUS CHANGE (must be reported within five business days)

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 non-permanent to long-term non-permanent	<input type="checkbox"/> Return to work (deadline to report does not apply)
<input type="checkbox"/> Transfer from another bargaining unit to GGU	
Termination, leave, layoff or transfer (select one):	Effective date:
<input type="checkbox"/> SLWOP (Seasonal Leave Without Pay)	<input type="checkbox"/> LWOP (Leave with Pay)
<input type="checkbox"/> Layoff	<input type="checkbox"/> FMLA (Family or Medical Leave)
<input type="checkbox"/> Going to on-call	<input type="checkbox"/> Separation from employment
<input type="checkbox"/> Transfer from GGU to to another bargaining unit	<input type="checkbox"/> Other

6. CERTIFICATION

By signing below, I certify all information provided on this form is true and correct. I understand that failure to disclose my spouse's eligibility and enrollment in employer-sponsored health care coverage (Section 2) could result in the retroactive assessment of the \$125/month surcharge deducted from your paycheck on a post-tax basis.

Employee signature:	Date:
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