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 list your dependents when you enroll or to notify the ASEA Health Trust Administrator of a family status change (for example, marriage, divorce or adding a dependent)

Reason for completing form: ☐ New member ☐ Marriage ☐ Divorce ☐ Adding dependent ☐ Name Change ☐ Other:

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:

Do you have other insurance coverage: ☐ Yes ☐ No If yes, what type? ☐ Medical ☐ Prescription ☐ Dental ☐ Vision

Name of policy holder: Policy number:

Effective date: Term date (if applicable): Type of plan: ☐ Active ☐ Retiree

Employer:

Insurance Company/Administrator address: Phone:

2. SPOUSE INFORMATION (MUST BE COMPLETED IF YOU ARE ENROLLING YOUR SPOUSE)

You must provide a copy of your marriage certificate for your spouse.

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.**

SPOUSE—OTHER INSURANCE COVERAGE

Do you have other insurance coverage (including Indian Health Services, Medicare or Medicaid): ☐ Yes ☐ No
If yes, what type? ☐ Medical ☐ Prescription ☐ Dental ☐ Vision

Name of policy holder: Policy number:

Effective date: Type of plan: ☐ Active ☐ Retiree

Insurance Company/Administrator:

Insurance Company/Administrator address: Phone:

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3. DEPENDENT INFORMATION

☑ My eligible dependents are listed below ☐ I have no eligible dependents

- You must provide proof of age and custody for **all dependent children**, 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: Medicare ID:

Relationship: ☐ Son ☐ Daughter ☐ Stepson ☐ Stepdaughter ☐ Other:

Please complete the questions below:

Is this dependent covered by other insurance (including Indian Health Services, Denali Kids, Medicare or Medicaid)? ☐ Yes ☐ No
If yes, please complete the following:

Is the other insurance coverage the same as the employee's? ☐ Yes ☐ No

Check the type(s) of coverage: ☐ Medical ☐ Prescription ☐ Dental ☐ Vision

Name of policy holder: Policy number:

Relationship to dependent: Effective date: Type of plan: ☐ Active ☐ Retiree

Employer: Insurance Company/Administrator:

Insurance Company/Administrator address: Phone:

Dependent name: Date of birth:

SSN: Medicare ID:

Relationship: ☐ Son ☐ Daughter ☐ Stepson ☐ Stepdaughter ☐ Other:

Please complete the questions below:

Is this dependent covered by other insurance (including Indian Health Services, Denali Kids, Medicare or Medicaid)? ☐ Yes ☐ No
If yes, please complete the following:

Is the other insurance coverage the same as the employee's? ☐ Yes ☐ No

Check the type(s) of coverage: ☐ Medical ☐ Prescription ☐ Dental ☐ Vision

Name of policy holder: Policy number:

Relationship to dependent: Effective date: Type of plan: ☐ Active ☐ Retiree

Employer: Insurance Company/Administrator:

Insurance Company/Administrator address: Phone:

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

4. 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 on a post-tax basis.

Employee signature: Not required if submitted on-line Date: