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

❑ Check this box if the Other Health Care Coverage information for you and your dependent(s) has not changed from the previous Plan Year (provided you have already submitted this information to the Trust).

If you HAVE changes in your other health care coverage, complete the following:

❑ 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:

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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: ❑ Add ❑ Remove Effective Date:

Relationship: ❑ Spouse ❑ Son ❑ Daughter ❑ Stepson ❑ Stepdaughter ❑ Other:

Dependent name: Date of birth:

SSN: ❑ Add ❑ Remove Effective Date:

Relationship: ❑ Spouse ❑ Son ❑ Daughter ❑ Stepson ❑ Stepdaughter ❑ 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
❑ Full-time to part-time	❑ Part-time to full-time
❑ Short-term non-permanent to long-term non-permanent	❑ Return to work (deadline to report does not apply)
❑ Transfer from another bargaining unit to GGU	

Termination, leave, layoff or transfer (select one):	Effective date:
❑ SLWOP (Seasonal Leave Without Pay)	❑ LWOP (Leave with Pay)
❑ Layoff	❑ FMLA (Family or Medical Leave)
❑ Going to on-call	❑ Separation from employment
❑ Transfer from GGU to to another bargaining unit	❑ 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: