CONFEDERATED TRIBES OF THE COLVILLE INDIAN RESERVATION

Application for Group Employee Medical Plan

Please Type or Print

Type of Enrollment: ACTIVE ____ DECLINE_____ CHANGE_____ **If Employee Is Declining Coverage: Reason:** _____	**Group #:**

Social Security Number ___ - ___ - ____		**Employee Name:** Last First Middle

Employee Home (Mailing) Address: **Street Address:** **City:** **State:** **Zip:**	**Home Phone: ( )**

Date of Birth / /	**Gender** ☐ Male ☐ Female	**Marital Status:** ___ Married ___ Single ___ Widowed ___ Divorced ____ Legally Separated **Date of Marriage:**

Date of Hire: / /	**IHS Eligible** ☐ No ☐ Yes	**Date Full Time:** / /	**Hours Worked Per Week:**	**Location/Division:** **Location # :** _____

INDICATE COVERAGE APPLIED FOR:

Plan Elected	Medical – RX - Vision
Employee Only	☐
Employee & Spouse	☐
Employee & Children	☐
Employee & Family	☐

If you do not want to elect Medical, RX or Vision coverages, please check the appropriate box below:

☐ **I want to decline all Medical RX Vision coverage for my dependents.**

DEPENDENTS PLEASE INDICATE BELOW THE REASON FOR DECLINING EACH PERSON. (Declination is at the top of the application)

Full Name of All Eligible Dependents	Gender	Date of Birth	Do You Want Coverage for This Eligible Dependent	Reason for Declining Coverage for this Eligible Dependent:
Spouse: **Spouse SS#:** **IHS Eligible** ☐ No ☐ Yes **CCT Enrolled Member/Descendent** ☐ **Other Native Enrolled Descendent** ☐	☐ Male ☐ Female		☐ Yes ☐ No	☐ Other Group Coverage ☐ Medicare/Medicaid ☐ Other
Child 1 #: **Child1SS#:** **IHS Eligible** ☐ No ☐ Yes **CCT Enrolled Member/Descendent** ☐ **Other Native Enrolled Descendent** ☐	☐ Male ☐ Female		☐ Yes ☐ No	☐ Other Group Coverage ☐ Medicare/Medicaid ☐ Other
Child #2: **Child2SS#:** **IHS Eligible** ☐ No ☐ Yes **CCT Enrolled Member/Descendent** ☐ **Other Native Enrolled Descendent** ☐	☐ Male ☐ Female		☐ Yes ☐ No	☐ Other Group Coverage ☐ Medicare/Medicaid ☐ Other

Child #3: **Child3SS#:** **IHS Eligible** ☐ **No** ☐ **Yes** **CCT Enrolled Member/Descendent** ☐ **Other Native Enrolled Descendent** ☐	☐**Male** ☐**Female**		☐ **Yes** ☐ **No**	☐**Other Group Coverage** ☐**Medicare/Medicaid** ☐ **Other**
Child #4: **Child #4 SS#:** **IHS Eligible** ☐ **No** ☐ **Yes** **CCT Enrolled Member/Descendent** ☐ **Other Native Enrolled Descendent** ☐	☐**Male** ☐**Female**		☐ **Yes** ☐ **No**	☐**Other Group Coverage** ☐**Medicare/Medicaid** ☐**Other**
Child #5: **Child# 5 SS#:** **IHS Eligible** **No** **Yes** **CCT Enrolled Member/Descendent** ☐ **Other Native Enrolled Descendent** ☐	☐**Male** ☐**Female**		☐ **Yes** ☐ **No**	☐**Other Group Coverage** ☐**Medicare/Medicaid** ☐**Other**
Child #6: **Child# 6 SS#:** **IHS Eligible** ☐ **No** ☐ **Yes** **CCT Enrolled Member/Descendent** ☐ **Other Native Enrolled Descendent** ☐	☐**Male** ☐**Female**		☐ **Yes** ☐ **No**	☐**Other Group Coverage** ☐**Medicare/Medicaid** ☐**Other**

Spouse and Other Coverage Information: ☐ **Yes, there is other Coverage** ☐**No, there is no other Coverage**
If there is any other coverage in effect for yourself or any other ELIGIBLE Dependent please complete this section

Name of Primary Insured with Other Coverage:	**Social Security Number** **-** **-**	**Relationship to Applicant**	**Employer Name and Phone Number**
Name and Address of other insurance:	**Effective Date of Other Coverage** **/** **/**	**Type of Coverage** **Med___ Vision___** **RX____**	**Who is Covered by other coverage?** **Self ___ Spouse____** **Child(ren)_____**

I hereby apply for the above indicated benefit(s) for myself and my eligible dependents (if applicable), as may be provided by my employer. I hereby acknowledge that the plan of health benefits by which I hereby seek coverage is, and shall be, subrogated to my rights against any third party in the amount and to the extent of any payments made by or on behalf of said plan to me or on my behalf. I agree to cooperate with said plan and its agents in the enforcement of said subrogation rights. I authorize the deduction from my earning of any mutually agreed upon contribution to be used towards the cost of the insurance or other benefits for which I am entitled and have elected.

I hereby authorize any hospital, doctor, clinic or similar installation, who has treated me or one of my eligible dependents, to furnish information regarding said treatment, including copies of all records, to HealthSmart Benefit Solutions or their designee. A photo-static copy of this authorization shall be considered as effective and valid as the original.

Signature: _____ Date_____

By signing this application I am stating that all information is true and accurate to the best of my knowledge and that this applicant is eligible for the coverage that has been applied for.

Client Representative: _____Date:_____