ENERGY NORTHWEST
People·Vision·Solutions

2006 Enrollment / Change Form

Human Resources Use Only

☐ **2006 Annual Open Enrollment** ☐ New enrollment Effective date: ____________

☐ Change in coverage

a. reason for change: ____________

b. date if change in status:

EMPLID: ____________

PS Entered: ____________

Audited: ____________

Confirmation: ____________

PEBB: ____________

Termination date: ____________ ☐ Part-time: ____________

Employee Information (please print)

Last Name		First Name	Middle Initial	
Employee #	Social Security #	Birthdate	Sex	
Street Address		City	State	Zip
Marital Status	Spouse name	Spouse birthdate	Phone number (home)	

Benefits Selections

For each plan, check your selected options:

* 1. Dental

☐ PPO (Washington Dental)
☐ DMO (Willamette Dental)
☐ No coverage

Coverage Level

☐ Participant only
☐ Participant and Spouse
☐ Participant and Child(ren)
☐ Participant, Spouse and Child(ren)

* 2. Vision

☐ Basic (VSP)
☐ Basic Plus (VSP)
☐ No coverage

Coverage Level

☐ Participant only
☐ Participant and Spouse
☐ Participant and Child(ren)
☐ Participant, Spouse and Child(ren)

* 3. Term Life Insurance

Check the box for the total coverage requested; refer to rules located on InsideEN

You must at a minimum enroll in the first Employee option of $25,000. (Cannot exceed 5 times your annual base pay nor exceed $500,000 maximum plan limit)

Employee

☐ $25,000 Core

$25,000 Core Included (Age Related)

☐ $50,000
☐ $100,000
☐ $150,000
☐ $200,000
☐ $250,000
☐ $300,000
☐ $350,000
☐ $400,000
☐ $450,000
☐ $500,000

Spouse

☐ $12,500 Core

$12,500 Core Included (Age Related)

☐ $25,000
☐ $50,000
☐ $75,000
☐ $100,000
☐ $125,000
☐ $150,000
☐ $175,000
☐ $200,000
☐ $225,000
☐ $250,000

☐ No coverage

Child(ren)

☐ $2,500
☐ $5,000
☐ $7,500
☐ $10,000
☐ No coverage

4. AD&D Insurance

Choose one option (cannot exceed ten times annual base pay nor exceed $500,000 maximum plan limit)

☐ Employee only
☐ Employee & family
☐ No coverage

Amount of Employee Coverage $ ____________ (Must be in increments of $10,000)

5. Short-Term Disability

Cost is for employee-only coverage for up to 60 days.

☐ 7 day waiting period
☐ 30 day waiting period
☐ No coverage

6. Long-Term Disability

You must at a minimum enroll in 40%/60 day waiting period. Cost is for employee only coverage.

☐ 40%/60 day waiting period

☐ 60%/180 day waiting period
☐ 60%/90 day waiting period
☐ 60%/60 day waiting period

* Paid on a pre-tax basis

Family Members to be Enrolled

SPOUSE

Last name	First name	Middle initial	Social Security Number
Street address	City	State	Zip
Birth date	Sex	Relationship to you	
Name of other medical coverage including Medicare		Group number	
POS and HMO Participants:	Primary Care Physician (PCP) name		

CHILD

Last name	First name	Middle initial	Social Security Number
Street address	City	State	Zip
Birth date	Sex	Relationship to you	
Name of other medical coverage including Medicare		Group number	
POS and HMO Participants:	Primary Care Physician (PCP) name		

CHILD

Last name	First name	Middle initial	Social Security Number
Street address	City	State	Zip
Birth date	Sex	Relationship to you	
Name of other medical coverage including Medicare		Group number	
POS and HMO Participants:	Primary Care Physician (PCP) name		

Beneficiary Designation

Make your beneficiary designation for Term Life Insurance and AD & D Insurance (If trust or will listed – name of trustee or executor required)

PRIMARY

1. Last name	First name	Middle initial
Social Security Number	Date of Birth	% designation
2. Last name	First name	Middle initial
Social Security Number	Date of Birth	% designation

SECONDARY

1. Last name	First name	Middle initial
Social Security Number	Date of Birth	% designation
2. Last name	First name	Middle initial
Social Security Number	Date of Birth	% designation

Pre-tax Waiver (Optional)

I wish to pay tax on my non-taxable benefits.

Employee Signature ______________________ Date ______________

Employee Authorization

REQUIRED

I understand that I have made an election for my benefits package for the plan year. Any choices I have made may only be altered as the result of a change in family status as defined in the plan or if an IRS ruling affects the plan. I also understand that any unused amounts in either spending account will be forfeited after the end of the year. I agree to have my benefits contributions deducted from my pay on a before-tax basis (for specified before-tax benefits) unless I have signed the waiver box above. I authorize all health care providers, claim processing agents, insurance and reinsurance agencies or other persons or organizations performing direct administrative professional, medical, or legal services or care in connection with my claims to disclose any information necessary for investigation, evaluation, or payment of a claim. I understand that reasonable efforts will be made to use, disclose, and request only the minimum amount of information needed to accomplish the intended purpose of the use, disclosure, or request. I further verify that the information I have furnished is correct.

Employee Signature ______________________ Date ______________