

2024 Addendum to Washington Small Group Employee Enrollment/Change Form

This form must accompany the Washington Small Group Employee Enrollment/Change Form and cannot be submitted as a stand-alone form. Use it when you have more dependents than you can record on the Washington Small Group Employee Enrollment/Change Form.

Employer section (To be completed by the employer. Subgroup and billgroup information required if coverage is selected.)

Company name¹ _____ Effective date of coverage¹ ____ / ____ / ____
Group #¹ _____ Medical subgroup # _____ Billgroup _____
Adult dental subgroup # _____ Billgroup _____
Pediatric dental subgroup # _____ Billgroup _____

A Employee information (Employee completes sections A, B, and C.)

Legal name (last, first, MI)¹ _____
Former/maiden name (if any) _____ Date of birth¹ ____ / ____ / ____ Social Security # _____
Sex¹ ☐ M ☐ F ☐ X ☐ Decline to provide (at this time) Pronoun(s) _____

B Dependent information

Dependent (child) legal name (last, first, MI)^{1,2} _____
Date of birth¹ ____ / ____ / ____ Social Security # _____
Sex¹ ☐ M ☐ F ☐ X ☐ Decline to provide (at this time) Pronoun(s) _____
Mobile phone _____ Disabled ☐ Yes ☐ No
☐ Medical
Dental (select one): ☐ Adult dental (19 years and older) ☐ Pediatric dental (18 years and younger) ☐ Waiving pediatric dental³
Other health insurance ☐ Yes ☐ No Insurance co. _____
Policy # _____ Medical record # (if any) _____

Dependent (child) legal name (last, first, MI)^{1,2} _____
Date of birth¹ ____ / ____ / ____ Social Security # _____
Sex¹ ☐ M ☐ F ☐ X ☐ Decline to provide (at this time) Pronoun(s) _____
Mobile phone _____ Disabled ☐ Yes ☐ No
☐ Medical
Dental (select one): ☐ Adult dental (19 years and older) ☐ Pediatric dental (18 years and younger) ☐ Waiving pediatric dental³
Other health insurance ☐ Yes ☐ No Insurance co. _____
Policy # _____ Medical record # (if any) _____

☐ Check here if another Addendum to Washington Small Group Employee Enrollment/Change Form is attached.

C Important

It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

Employee signature¹ _____ Date ____ / ____ / ____

¹ Required

² Eligible through the last day of the month of their 26th birthday month or for dependent children over the age of 26 with a developmental disability, mental illness, or physical disability.
Per state law, if children of the insured employee are covered, children of state registered domestic partners are covered on the same basis. If your employer chooses to provide coverage for non-state registered domestic partners, and children of the insured employee are covered, children of non-state registered domestic partners are covered on the same basis.

³ By checking this box you are attesting that the member has pediatric dental coverage elsewhere that is compliant with the essential health benefits provision of the Affordable Care Act.