ARIZONA TECHNOLOGY COUNCIL
a place to connect and grow

EMPLOYEE ENROLLMENT APPLICATION, CANCELLATION, AND WAIVER

Effective Date of Enrollment or Change:			
Employer Name:			
Class:		**Medical Plan:**	

Check One:				
☐New Enrollee	☐Cancellation	☐Name Change	☐Add Dependents	☐Beneficiary Change
☐Delete Dependents	☐Address Change	☐Waiving	☐COBRA start date:	

Personal Information: (Please Print Clearly)						
Employee Name:	Last:		First:			MI:
Address:	Street:		City:	State:		Zip:
Area Code/Phone:		**Email:**				
SSN:		**Date of Birth:**		**Gender:**	☐Male	☐Female
Marital Status:	☐Single ☐Married	**Date of Marriage:**				
Hire Date:		**Hours per week:**				
Annual salary (if STD/LTD included):	$					

Employee Elections:					
Medical:	☐Add ☐Delete	**Dental:**	☐Add ☐Delete	**Vision:**	☐Add ☐Delete

Name of Enrolling Dependent(s)	**DOB**	**Relationship**	**Sex**	**SSN**	**Elections**		
					Medical	**Dental**	**Vision**
		☐Spouse ☐Child ☐Domestic Part.	☐Male ☐Female		☐Add ☐Delete	☐Add ☐Delete	☐Add ☐Delete
		☐Child	☐Male ☐Female		☐Add ☐Delete	☐Add ☐Delete	☐Add ☐Delete
		☐Child	☐Male ☐Female		☐Add ☐Delete	☐Add ☐Delete	☐Add ☐Delete
		☐Child	☐Male ☐Female		☐Add ☐Delete	☐Add ☐Delete	☐Add ☐Delete

Beneficiary for Basic Life / AD&D Insurance Benefit			
Name:		**Relationship:**	
Address:			

Current Coverage, Prior Coverage, and Coordination of Benefits					
Name of Family Member	**Other Employer (or Medicare)**	**Date Coverage Began**	**Date Coverage Ended**	**Name of Insurance Carrier**	**Plan Number**

By signing below, I acknowledge that I have read, understand, and agree to the Terms & Conditions on all pages of this form.	
Employee Signature:	**Date:**

TERMS & CONDITIONS

Application Agreement

I hereby apply for coverage under the contract between the issuer and my employer or group, and I agree with the terms of the contract. I also apply for the same coverage for my spouse and/or my children listed on this application. I agree that my listed dependents and I meet all the eligibility criteria set forth in the outline of benefits and/or the contract.

I agree to pay in advance the appropriate rates for myself and listed dependents and authorize rate increases as the company deems necessary.

Anti-Fraud Statement

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. I have provided these answers as part of the application procedure required by the issuer to enroll in coverage and I agree that all information completed on this form is true, correct, and complete. I understand that the issuer will rely on each answer in making coverage and rating determinations.

Release of Information

I acknowledge and understand my health plan may request or disclose health information about me or my dependents (persons who are eligible for benefits coverage and are listed on the enrollment form) for the purpose of facilitating health care treatment, payment or for the purpose of business operations necessary to administer health care benefits; or as required by law. Health information requested or disclosed may be related to treatment or services performed by: a physician, dentist, pharmacist or other physical or behavioral health care practitioner; a clinic, hospital, long term care or other medical facility; any other institution providing care treatment, consultation, pharmaceuticals or supplies; or an insurance carrier or group health plan. Health information requested or disclosed may include, but is not limited to: claims records, correspondence, medical records, billing statements, diagnostic imaging reports, laboratory reports, dental records, or hospital records (including nursing records and progress notes). This acknowledgement does not apply to obtaining information regarding psychotherapy notes. A separate authorization will be used for psychotherapy notes.

Coverage Underwritten By:	
Medical & Dental Benefits:	Blue Cross Blue Shield of Arizona; 2444 W Las Palmaritas Dr., Phoenix, AZ 85021
Vision Insurance Benefits:	VSP Vision Care, Inc. (HCSC); 3333 Quality Drive, Rancho Cordova, CA 95670
Life Insurance Benefits:	Metropolitan Life Insurance Co.; 200 Park Avenue, New York, NY 10166
Employee Assistance Program:	CuraLinc Healthcare; 314 West Superior Street, Chicago, IL 60654

Administered By Vimly Benefit Solutions:	
Physical Address:	12121 Harbour Reach Drive, Suite 105, Mukilteo, WA 98275
Mailing Address:	P.O. Box 6, Mukilteo, WA 98275
Phone:	(425) 771-7359 **Fax:** (425) 771-1226
Email:	aztc@vimly.com
TTY:	(800) 842-5357