

**Mark all boxes and complete all sections that apply. Return completed form to your Human Resources Department.**

APPLICANT	Your Name (Last, First, Middle)		Group Name <b>Washington Counties Insurance Fund (WCIF)</b>		Group Number(s) <b>645273</b>	
	Your Address		City		State	ZIP
	Your Soc. Sec. No.	Date of Birth		<input type="checkbox"/> Male <input type="checkbox"/> Female		
	Employer			Job Title/Occupation		
DISABILITY	<p><i>Check with your Human Resources Department about coverage options available to you and Evidence Of Insurability requirements.</i></p> <p><b>Voluntary Short Term Disability</b></p> <p><input type="checkbox"/> Option 1, 90 days</p> <p><input type="checkbox"/> Option 2, 180 days</p>					
	<p><i>Use this section only when you wish to make a change after insurance becomes effective. Complete all boxes and sections that apply.</i></p> <p><input type="checkbox"/> Name Change      Former name _____      <input type="checkbox"/> Other _____</p>					
SIGNATURE	<p>I wish to make the choices indicated on this form. If electing coverage, I authorize deductions from my wages to cover my contribution, if required, toward the cost of insurance. I understand that my deduction amount will change if my coverage or costs change.</p>					
	Member/Employee Signature Required				Date (Mo/Day/Yr)	
<p><b>Human Resources Department - Complete this section. Retain form for your records.</b></p>						
Dvsn ID <b>0001</b>	Billing Cat. <b>0100</b>	Date of Hire/Rehire	Hrs. Worked Per Wk.	Earnings \$ _____ Per: <input type="checkbox"/> Hour <input type="checkbox"/> Wk <input type="checkbox"/> Mo <input type="checkbox"/> Yr		