WCIF
WASHINGTON COUNTIES INSURANCE FUND

Participant Information

Employer Name ______________________

Employee Name ____ Date of Birth ____________

First Last Middle

Address ________________________________ City ____________ State ______ ZIP Code ______

Day Telephone ( ) __________

Pay Frequency (circle one): Monthly / Semi-Monthly / Bi-Weekly (24) / Bi-Weekly (26) / Weekly / Other

Email Address* ____________________________ Hire Date ____________ Hours worked / week ___

*Email address is mandatory, account access is provided to participants through this address.

Gender (Please circle one): Male / Female Marital Status (Please circle one): Married / Single

Enrollment

Cause for Enrollment: ☐ **Open Enrollment** ☐ **New Hire** ☐ **Status Change** **(marriage/birth/divorce/death)**

Type of Coverage ☐ **Single** ☐ **Family** ☐ **Limited Family**

Dependent Information

First Name	Last Name	Birth Date	Relationship	Gender (M or F)

Per IRS regulations, any expenses you incur must be within the plan year. Expenses you incur may not be reimbursed by any other source, such as insurance; You must provide proper documentation to receive payment. You cannot change or revoke your election during the plan year unless there is a specific change of status and your employer allows such changes.

Participant Banking Information

Bank Name ________________________________ Account Type ☐ Checking ☐ Savings

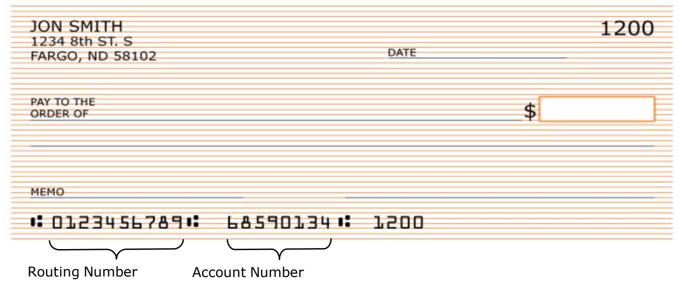
Routing Number ________________________ Account Number ________________________

Street Address ____________________ City ________________ State ______ Zip ______

(This account information is used so that claim repayments can be made by direct deposit. If Banking information is not provided then repayments for items not purchased with the benefit debit card will be made via a paper check, mailed to the participant address listed in section one)

I hereby certify the information provided on this form is accurate. Further, I understand my completion and submission of this form authorizes Benefit Solutions, Inc. to issue payment directly to the specified account unless I notify them otherwise.

Initials: ________ Date: ______________________



Employer Information (employer completes this section)

Plan Effective Date ____________ Termination Date ____________

mm/dd/yyyy mm/dd/yyyy

HRA Annual Individual Total $ ____________ HRA Annual Family Total $ ____________

This is the amount the employer will fund in the currrent plan year per employee, and then per dependent

Participant Signature: ______________________________ Date: ____________

Employer Signature: ______________________________ Date: ____________