

# 2020 GROUP BENEFIT ENROLLMENT & CHANGE FORM | NON-MEDICAL

## FOR ACTIVE EMPLOYEES



### INSTRUCTIONS:

Complete and submit this form to your employer to enroll or make changes in your and/or your dependent(s) WCIF benefits.

**THIS WILL REPLACE ANY BENEFIT ENROLLMENT INFORMATION YOU HAVE SUBMITTED IN THE PAST**

Coverage Effective Date

#### THIS IS AN APPLICATION FOR (check one):

Open Enrollment  
  New Group  
  New Employee  
  New Dependent  
  Change in Status

#### EMPLOYER SECTION ONLY

Employer Name:			Vimly, Inc. Account #:	Class Code (if applicable):
Date of Hire:	Date Eligible for Benefits:	Annual Salary:	Approved by (administrator name):	
Date Approved:	Special Note(s) / Direction(s):			

#### SECTION I: EMPLOYEE INFORMATION

Last Name:	First Name:	Social Security #:	Date of Birth:	
Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male	Status: <input type="checkbox"/> Single <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Lawful Spouse	Hours Worked per Week:		
Mailing Address:		City:	State:	Zip:
Primary Phone (mandatory):	Alternate Phone:	Email Address (mandatory):		

**EMPLOYEE NAME:** \_\_\_\_\_**SECTION II: DEMOGRAPHIC & ELIGIBILITY CHANGE INFORMATION** (existing employees only)

Complete the following to change existing enrollment information. If you are a new enrollee or do not have demographic or eligibility changes, proceed to Section III.  
**NOTE: Some changes require additional documentation as noted.**

**Date of Event:** \_\_\_\_\_
 **CHANGE** (If you are only changing your name or address you may submit a Demographic Change Form)

 Open Enrollment

 Name

 Address

 Employment Status (causing change in benefit eligibility)

 **ADDITION of employee and/or dependent(s) coverage due to:**
 Newly acquired child due to birth, adoption, foster care placement, legal guardianship, or marriage  
 + Attach documentation as appropriate

 Marriage or registration of qualified Domestic Partnership  
 + Attach copy of Marriage License, Domestic Partnership (as applicable), Partnership registration documentation, or Affidavit

 Court order or qualified medical child support order (QMCSO) + Attach copy of QMCSO

 Loss of other group coverage  
 + Attach copy of Proof of Loss  
 Previous carrier: \_\_\_\_\_

 **TERMINATION / DROP of dependent(s) coverage due to:**
 Divorce or termination of Domestic Partnership  
 + Attach Notice to Employer of a Qualifying Event, and copy of Final Divorce Decree, or Termination of Domestic Partnership Form

 Legal separation + Attach Notice to Employer of a Qualifying Event, and copy of Final Separation Agreement

 Loss of eligibility for WCIF coverage + Attach Notice to Employer of a Qualifying Event
**Dependent(s) to be dropped (full name):**

1)

2)

3)

4)

**SECTION III: DEPENDENT ENROLLMENT****ENROLL THE FOLLOWING DEPENDENT(S):**

- Lawful Spouse or Domestic Partner | Marriage Date or Registration of Domestic Partnership: \_\_\_\_\_  
 Child(ren) to Age 26

**DEPENDENT INFORMATION** (Social Security Numbers (SSNs) are mandatory)**ENROLL IN:**

Dental

Vision

DEPENDENT INFORMATION (Social Security Numbers (SSNs) are mandatory)					Dental	Vision
#1	Last Name:		First Name:		<input type="checkbox"/> Female <input type="checkbox"/> Male	<input type="checkbox"/>
	SSN:	Date of Birth:	Relationship:	Same Address as Employee? <input type="checkbox"/> Yes <input type="checkbox"/> No (if NO see below)		
#2	Last Name:		First Name:		<input type="checkbox"/> Female <input type="checkbox"/> Male	<input type="checkbox"/>
	SSN:	Date of Birth:	Relationship:	Same Address as Employee? <input type="checkbox"/> Yes <input type="checkbox"/> No (if NO see below)		
#3	Last Name:		First Name:		<input type="checkbox"/> Female <input type="checkbox"/> Male	<input type="checkbox"/>
	SSN:	Date of Birth:	Relationship:	Same Address as Employee? <input type="checkbox"/> Yes <input type="checkbox"/> No (if NO see below)		

**EMPLOYEE NAME:**

#4	Last Name:		First Name:		Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male	Dental	Vision
	SSN:	Date of Birth:	Relationship:	Same Address as Employee? <input type="checkbox"/> Yes <input type="checkbox"/> No (if NO see below)		<input type="checkbox"/>	<input type="checkbox"/>
#5	Last Name:		First Name:		Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male	Dental	Vision
	SSN:	Date of Birth:	Relationship:	Same Address as Employee? <input type="checkbox"/> Yes <input type="checkbox"/> No (if NO see below)		<input type="checkbox"/>	<input type="checkbox"/>

**DEPENDENT(S) - OTHER ADDRESS**

If you checked NO under "Same Address as Employee" for any of the above dependents, complete the following.

Address:	City:	State:	Zip:
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Dependents under other address (as listed above):  #1  #2  #3  #4  #5

For additional dependent(s) and/or additional dependent addresses, please attach a separate sheet of paper.

**SECTION IV: PLAN ELECTION****DENTAL**

- Delta Dental of Washington | Plan: \_\_\_\_\_  
 Willamette Dental of Washington | Plan: \_\_\_\_\_

**VISION**

- VSP Vision Care, Inc. | Plan: \_\_\_\_\_

**VOLUNTARY LINES OF COVERAGE**

See your *Human Resources Department* for **Standard Insurance Company** enrollment forms:

- Voluntary Long Term Disability Buy-up (LTD Buy-up)
- Voluntary Accidental Death & Dismemberment (VAD&D)
- Voluntary Term Life (VTL)
- Voluntary Short Term Disability (VSTD)

**SECTION V: GROUP BASIC LIFE / ACCIDENTAL DEATH & DISMEMBERMENT BENEFICIARY DESIGNATION**

(employer provides to all employees)

**In the event of my death, all proceeds from my employer-paid group basic life / accidental death and dismemberment insurance shall be paid to:**

Primary Beneficiary (full name):	Relationship:	Benefit %:
Address (Street, City, State, Zip):		SSN:
Contingent Beneficiary ( <i>optional</i> ):	Relationship:	Benefit %:
Address (Street, City, State, Zip):		SSN:

If you would like to designate additional beneficiaries, you may submit an expanded Beneficiary Designation Form available through your Human Resources or at <http://wcif.net/employees/forms>.

**EMPLOYEE NAME:** \_\_\_\_\_

**SECTION VI: SIGNATURE**

By signing this form, I declare that the information I have provided is true, complete, and correct. I understand that 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. WCIF may verify eligibility for myself and my family members. If I or my eligible dependent(s) choose to waive coverage, I understand that I/we can re-enroll during the annual open enrollment period. This form replaces all previous forms and submissions I have made for WCIF benefits.

Employee Name: \_\_\_\_\_

Employee Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**Delta Dental of Washington**

400 Fairview Avenue N, Suite 800  
Seattle, WA 98109  
00497 00498 00500  
00501 00502 00478

**Willamette Dental of Washington Inc.**

6950 NE Campus Way  
Hillsboro, OR 97124  
WA204

**VSP Vision Care, Inc.**

3333 Quality Drive  
Rancho Cordova, CA 95670  
30029829

**Standard Insurance Company**

1100 SW 6th Ave  
Portland, OR 97204  
645273

**First Choice Health EAP**

600 University Street, Suite 1400  
Seattle, WA 98101