

2021 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	
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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
**Washington State Registered Domestic Partners are treated the same as a spouse*

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"/>	<input type="checkbox"/>
	SSN:		Relationship:			
#2	Last Name:		First Name:		<input type="checkbox"/>	<input type="checkbox"/>
	SSN:		Relationship:			
#3	Last Name:		First Name:		<input type="checkbox"/>	<input type="checkbox"/>
	SSN:		Relationship:			

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 Term Life (VTL)
- Voluntary Accidental Death & Dismemberment (VAD&D)
- 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 (optional):	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