GROUP BENEFIT ENROLLMENT & CHANGE FORM | NON-MEDICAL

FOR ACTIVE EMPLOYEES

Submit this form to your employer to enroll and/or make changes in your and/or your dependents' WCIF benefits. **THIS WILL REPLACE ANY BENEFIT ENROLLMENT INFORMATION YOU HAVE SUBMITTED IN THE PAST.**

THIS IS AN APPLICATION FOR (check one):

☐ **Open Enrollment** ☐ **New Employee** ☐ **New Dependent** ☐ **Change in Status** | **Effective Date:**

EMPLOYER SECTION

Employer Name: Kitsap County			BSI Account #: 55	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

Name (*First, Middle, Last*):		Social Security Number:		Date of Birth:
Gender: ☐ Male ☐ Female	Status: ☐ Single ☐ Married or in qualified Domestic Partnership			Hours Worked per Week:
Address:		City:	State:	Zip:
Primary Phone (*mandatory*):	Alternate Phone:	Email Address (*mandatory*):		

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
- ☐ Marriage or registration of qualified Domestic Partnership + Attach copy of Marriage License, Partnership registration documentation, or Affidavit of Domestic Partnership (as applicable)
- ☐ Court order or qualified medical child support order (QMCSO) + Attach copy of QMCSO
- ☐ Loss of other comparable group coverage

☐ **TERMINATION / DROP of dependent(s) coverage due to:**

- ☐ Divorce or termination of Domestic Partnership + Attach Notice to Employer of a Qualifying Event
- ☐ Legal separation + Attach Notice to Employer of a Qualifying Event
- ☐ Anticipation of divorce
- ☐ Loss of eligibility for WCIF coverage + Attach Notice to Employer of a Qualifying Event
- ☐ OTHER | EXPLANATION:

Dependent(s) to be dropped (*full name*):	1)	3)
	2)	4)

Employee Name:

SECTION III: PLAN ELECTION

DENTAL
(Employee enrollment is mandatory if your employer offers dental coverage through WCIF. Waiver not allowed.)

☐ **Washington Dental Service (WDS) Dental PPO | Plan: WDS2** ☐ **WDS4** ☐

☐ **Willamette Dental of Washington Inc (WDW) Dental**

LIFE (Mandatory coverage for all employees)

☒ **Standard Insurance Company Group Basic Life** (Employer paid) | **Plan: $24,000**

Contact your Human Resources Department for information on additional voluntary life coverage.

SECTION IV: DEPENDENT ENROLLMENT

ENROLL THE FOLLOWING DEPENDENT(S):

☐ **Spouse or Domestic Partner** | Marriage Date or Registration of Domestic Partnership: _____

☐ **Child(ren) to Age 26** ☐ **Disabled Child(ren) Past Age 26**

Dependents who are eligible for WCIF coverage include:

- A lawful spouse or domestic partner, and
- Children to age 26 including biological, step, foster, adopted children from the date of assumption of legal obligation for total or partial support, children required by court order or qualified medical child support order (QMCSO) to be covered by a participant.

DEPENDENT INFORMATION ***(Social Security Numbers (SSNs) are mandatory)***					ENROLL IN:		
					Dental*		Life
#1	Last Name:		First Name:	Gender: ☐ Male ☐ Female	☐		☐
	SSN:	Date of Birth:	Relationship:	Same Address as Employee? ☐ Yes ☐ No *(if **NO** see below)*			
#2	Last Name:		First Name:	Gender: ☐ Male ☐ Female	☐		☐
	SSN:	Date of Birth:	Relationship:	Same Address as Employee? ☐ Yes ☐ No *(if **NO** see below)*			
#3	Last Name:		First Name:	Gender: ☐ Male ☐ Female	☐		☐
	SSN:	Date of Birth:	Relationship:	Same Address as Employee? ☐ Yes ☐ No *(if **NO** see below)*			

Employee Name:

#4	Last Name:		First Name:	Gender: ☐ Male ☐ Female	☐		☐
	SSN:	Date of Birth:	Relationship:	Same Address as Employee? ☐ Yes ☐ No *(if **NO** see below)*			
#5	Last Name:		First Name:	Gender: ☐ Male ☐ Female	☐		☐
	SSN:	Date of Birth:	Relationship:	Same Address as Employee? ☐ Yes ☐ No *(if **NO** see below)*			

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:

Dependents under other address *(as listed above)*: ☐ #1 ☐ #2 ☐ #3 ☐ #4 ☐ #5

For additional dependents and/or additional dependent addresses please attach a separate sheet of paper.

***DEPENDENTS WHO ARE DROPPED FROM DENTAL OR VISION MAY NOT BE ADDED AGAIN WITHOUT PROOF OF CONTINUOUS COVERAGE.**

SECTION VI: GROUP BASIC LIFE BENEFICIARY DESIGNATION

In the event of my death all proceeds from my group basic life insurance shall be paid to:

Primary Beneficiary (full name):	**Address** (Street, City, State, Zip):	**Relationship:**	**SSN:**	**Benefit %:**
Contingent Beneficiary *(optional)*:	Address:	Relationship:	SSN:	Benefit %:
Contingent Beneficiary *(optional)*:	Address:	Relationship:	SSN:	Benefit %:

If you would like to designate more beneficiaries, you may submit an expanded *Beneficiary Designation Form* available through your Human Resources and at http://www.wcif.net/PublicForms.html.

SECTION VII: 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 dependents choose to waive coverage, I understand that I/we can re-enroll during the annual open enrollment period. If I waive medical for myself, I also waive medical for my eligible dependents. This form replaces all previous forms and submissions I have made for WCIF benefits.

Employee Name: ______________________ Print Form

Employee Signature: ______________________ Date: __________

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00501 00502

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