2026 GROUP BENEFIT ENROLLMENT & CHANGE FORM
ALL LINES | *FOR ACTIVE EMPLOYEES*

WCIF
Washington Counties Insurance Fund

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 (Required Information)

Last Name:	First Name:		Social Security #:	Date of Birth:
Gender at Birth: ☐ Female ☐ Male	Status: ☐ Single ☐ Qualified Domestic Partnership ☐ Married			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*

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

Marriage Date or Registration of Qualified Domestic Partnership:

☐ Child(ren) to Age 26**

***If Dependent children are covered, they are covered through the age of 25 regardless of marital status, student status, or eligibility for coverage under another plan.*

ENROLL IN
If left unmarked, dependent enrollment will default to EE plan selections.

DEPENDENT INFORMATION
Name, DOB, and Social Security Numbers (SSNs) are mandatory.

Medical	Dental	Vision		Last Name:	First Name:		Gender at Birth: ☐ F ☐ M
☐	☐	☐	**#1**	Same address as employee? ☐ Yes ☐ No	Relationship:	Date of Birth:	SSN:
Medical	Dental	Vision		Last Name:	First Name:		Gender at Birth: ☐ F ☐ M
☐	☐	☐	**#2**	Same address as employee? ☐ Yes ☐ No	Relationship:	Date of Birth:	SSN:

EMPLOYEE NAME:

Medical	Dental	Vision		Last Name:	First Name:		Gender at Birth: ☐ F ☐ M
☐	☐	☐	**#3**	Same address as employee? ☐ Yes ☐ No	Relationship:	Date of Birth:	SSN:
Medical	Dental	Vision		Last Name:	First Name:		Gender at Birth: ☐ F ☐ M
☐	☐	☐	**#4**	Same address as employee? ☐ Yes ☐ No	Relationship:	Date of Birth:	SSN:
Medical	Dental	Vision		Last Name:	First Name:		Gender at Birth: ☐ F ☐ M
☐	☐	☐	**#5**	Same address as employee? ☐ Yes ☐ No	Relationship:	Date of Birth:	SSN:

DEPENDENT(S) - OTHER ADDRESSES
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 dependent(s) and/or additional dependent addresses, please attach a separate sheet of paper.

SECTION IV: PLAN ELECTION

MEDICAL (Select ONE carrier and indicate plan name)

☐ **Kaiser Foundation Health Plan of WA Options, Inc.** _____

All employees ENROLLED in a WCIF medical plan will automatically receive First Choice Health Employee Assistance Program (EAP) and The Standard Insurance Company Base Long Term Disability (Base LTD) coverage.

VOLUNTARY LINES OF COVERAGE

See your Human Resources Department for coverages available to you, including plan information and enrollment forms.

- Voluntary Life (VL)
- Voluntary Accidental Death & Dismemberment (VAD&D)

EMPLOYEE NAME:

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 (full name) *(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.
**Total must equal 100% for each Primary and Contingent.*

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. If I waive medical for myself, I also waive medical for my eligible dependent(s). This form replaces all previous forms and submissions I have made for WCIF benefits.

Employee Name: _____

Employee Signature: _____ Date: _____

Kaiser Foundation Health Plan of WA Options, Inc.
2715 Naches Avenue SW
Renton, WA 98057
Plan number unique to employer.
Contact WCIF at (800) 344-8570 to obtain.

First Choice Health EAP
600 University Street, Ste 1400 Seattle,
WA 98101