

2027 GROUP BENEFIT ENROLLMENT & CHANGE FORM

ALL LINES | 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 <i>(if applicable):</i>
Date of Hire:	Date Eligible for Benefits:	Annual Salary <i>(Required):</i>	Approved by <i>(administrator name):</i>	
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 <i>If left unmarked, dependent enrollment will default to EE plan selections.</i> DEPENDENT INFORMATION <i>Name, DOB, and Social Security Numbers (SSNs) are mandatory.</i>								
Medical	Dental	Vision	#1	Last Name:		First Name:		Gender at Birth: ☐ F ☐ M
☐	☐	☐		Same address as employee? ☐ Yes ☐ No		Relationship:	Date of Birth:	SSN:
Medical	Dental	Vision	#2	Last Name:		First Name:		Gender at Birth: ☐ F ☐ M
☐	☐	☐		Same address as employee? ☐ Yes ☐ No		Relationship:	Date of Birth:	SSN:

EMPLOYEE NAME:							
Medical ☐	Dental ☐	Vision ☐	#3	Last Name:	First Name:		Gender at Birth: ☐ F ☐ M
				Same address as employee? ☐ Yes ☐ No	Relationship:	Date of Birth:	SSN:
Medical ☐	Dental ☐	Vision ☐	#4	Last Name:	First Name:		Gender at Birth: ☐ F ☐ M
				Same address as employee? ☐ Yes ☐ No	Relationship:	Date of Birth:	SSN:
Medical ☐	Dental ☐	Vision ☐	#5	Last Name:	First Name:		Gender at Birth: ☐ F ☐ M
				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							
☐ Core (HMO) - Kaiser Foundation Health Plan of WA Plan: _____							
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

Obsidian Insurance Company - Medical Air Services Association (MASA)
Offers WA Emergency Shield Indemnity Program for air & ground ambulance

☐ **Single** ☐ **Family**

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)**

SECTION V: GROUP BASIC LIFE / ACCIDENTAL DEATH & DISMEMBERMENT BENEFICIARY DESIGNATION (employer provides to all employees)

Designations are not valid unless signed, dated, and delivered in accordance with the terms of the Group Policy during your lifetime.

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 %*:
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Address (Street, City, State, Zip):

SSN:	Date of Birth:	Phone Number:
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Contingent Beneficiary (full name) (<i>optional</i>):	Relationship:	Benefit %*:
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Address (Street, City, State, Zip):

SSN:	Date of Birth:	Phone Number:
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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: _____

Premera Blue Cross

7001 220th St SW
Mountlake Terrace, WA 98043
Plan number unique to employer.
Contact WCIF at (800) 344-8570 to obtain.
Premera Blue Cross is an independent licensee of the
Blue Cross Blue Shield Association.

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.

Kaiser Foundation Health Plan of WA

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

Delta Dental of Washington

400 Fairview Avenue N
Seattle, WA 98109
Plan Numbers: 00497 / 00498 / 09519 / 00501
00502 / 00478

Willamette Dental of Washington, Inc.

6950 NE Campus Way
Hillsboro, OR 97124-5611
Plan Number: WA204

Standard Insurance Company

1100 SW 6th Avenue
Portland, OR 97204
Plan Number: 645273

VSP Vision Care, Inc.

3333 Quality Drive
Rancho Cordova, CA 95670
Plan Number: 30029829

First Choice Health EAP

600 University Street, Ste 1400
Seattle, WA 98101

Metropolitan Life Insurance Company

200 Park Avenue
New York, NY 10166-0188
Plan number unique to member.

Obsidian Insurance Company

1330 Avenue of the Americas, Suite 23A
New York, NY 10019