2025 GROUP BENEFIT ENROLLMENT & CHANGE FORM | NON-MEDICAL

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* | Marriage Date or Registration of Qualified Domestic Partnership: _____

☐ Child(ren) to Age 26

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

ENROLL IN *If left unmarked, dependent enrollment will default to EE plan selections.*		**DEPENDENT INFORMATION** *Name, DOB, and Social Security Numbers (SSNs) are mandatory.*				
Dental	Vision		Last Name:	First Name:		Gender at Birth: ☐ Female ☐ Male
☐	☐	**#1**	Same address as employee? ☐ Yes ☐ No	Relationship:	Date of Birth:	SSN:
Dental	Vision		Last Name:	First Name:		Gender at Birth: ☐ Female ☐ Male
☐	☐	**#2**	Same address as employee? ☐ ☐	Relationship:	Date of Birth:	SSN:
Dental	Vision		Last Name:	First Name:		Gender at Birth: ☐ Female ☐ Male
☐	☐	**#3**	Same address as employee? ☐ ☐	Relationship:	Date of Birth:	SSN:

EMPLOYEE NAME: _____

Dental ☐	Vision ☐	#4	Last Name:	First Name:		Gender at Birth: ☐Female ☐Male
			Same address as employee? ☐ ☐	Relationship:	Date of Birth:	SSN:
Dental ☐	Vision ☐	#5	Last Name:	First Name:		Gender at Birth: ☐Female ☐Male
			Same address as employee? ☐ ☐	Relationship:	Date of Birth:	SSN:

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

SECTION IV: PLAN ELECTION

DENTAL (Select One Carrier and indicate plan name)

☐ **Delta Dental of Washington | Plan:** PLAN D
☐ **Willamette Dental of Washington | Plan:** HIGH PLAN

VISION (Indicate Plan name)

☒ **VSP Vision Care, Inc. | Plan:** STANDARD PLAN

VOLUNTARY LINES OF COVERAGE

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

- ~~**Short Term Disability (STD)**~~
- ~~**Long Term Disability Buy-up (LTD Buy-up)**~~
- **Voluntary Life (VL)**
- **Voluntary Accidental Death & Dismemberment (VAD&D)**
- ~~**Hospital Indemnity**~~
- ~~**Accident Insurance**~~
- ~~**Critical Illness**~~
- **Group Legal**
- **Aura Identity Theft & Fraud Protection**

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.

*Total must equal 100% for each Primary and Contingent.

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
Plan Numbers: 00497 00498 00500
00501 00502 00478

Willamette Dental of Washington Inc.
6950 NE Campus Way
Hillsboro, OR 97124
Plan Number: WA204

VSP Vision Care, Inc.
3333 Quality Drive
Rancho Cordova, CA 95670
Plan Number: 30029829

Standard Insurance Company
1100 SW 6th Ave
Portland, OR 97204
Plan Number: 645273

First Choice Health EAP
400 Westlake Ave N. Suite 1500
Seattle, WA 98109

Metropolitan Life Insurance
Company 200 Park Avenue
New York, NY 10166
Plan number unique to member.