BENEFITS ENROLLMENT FORM

Effective date______________________

Check appropriate box: ❑ COBRA enrollment ❑ Open enrollment ❑ Name change ❑ Divorce ❑ Address change ❑ Birth/adoption ❑ Marriage/domestic partnership ❑ Beneficiary change ❑ Date hours changed _____/_____/_____ ❑ Date prior coverage ended _____/_____/_____

❑ Reason for change____ Legal documentation required for: ❑ Adoption ❑ Medical support order ❑ Legal guardianship

Print clearly and complete all sections. Remember to sign and date the form, then return your completed form to the Benefits Office, CAB. Retain the pink copy for your records.

1. EMPLOYEE INFORMATION

Hire date________________ Employee #________________________

____

Last name First M.I. Birthdate Social Security Number

____

Address City State Zip Code

Home phone____ Work phone____ ❑ Full time ❑ Part time

2. MEDICAL

A. Check appropriate medical plan selection:

❑ Premera Blue Cross (must fill out WEA Select Enrollment Form)

❑ Group Health Cooperative (must fill out Group Health Enrollment Form)

❑ I do not wish to enroll for medical coverage at this time. I understand that I will not be able to enroll for medical coverage until the next annual enrollment period unless I have a change in family status.

3. VISION/DENTAL

A. Check appropriate box:

❑ United Concordia Dental (815192)

❑ Willamette Dental Group (Z130)

❑ I do not wish to enroll for dental coverage at this time. I understand that I will not be able to enroll for dental coverage until the next annual enrollment period unless I have a change in family status.

B. Dependent Information

List all family members who are eligible for vision and dental coverage. (Your spouse and all dependent children under age 26 are eligible.)

Only dependents that are listed below will have vision/dental coverage. (Attach a sheet with additional dependent information, if necessary.)

Dental (Yes/No)	Vision	Last name	First	M.I.	Sex	Birthdate	Social Security #
❑ ❑	☒	Employee					
❑ ❑	☒	Spouse					
❑ ❑	☒	Domestic partner *(must complete affidavit of qualifying domestic partner)*					
❑ ❑	☒	Child					
❑ ❑	☒	Child					
❑ ❑	☒	Child					

4. LIFE INSURANCE

A. Optional Employee Life Insurance

This is in addition to the Basic Life Insurance ($25,000) which is automatically provided.

❑ 1 x annual pay (rounded up to next $10,000)
❑ 2 x annual pay (rounded up to next $10,000)
❑ 3 x annual pay (rounded up to next $10,000)*
❑ 4 x annual pay (rounded up to next $10,000)*
❑ 5 x annual pay (rounded up to next $10,000)*
❑ None

Requires you to complete a proof of good health form. You will also have to provide proof of good health to increase your current coverage by two or more steps. Proof of good health is required for all optional steps including optional dependent life insurance if not elected at time of hire.

B. Optional Dependent Life Insurance

Spouse/domestic partner: ❑ $12,500 ❑ None Children: ❑ $5,000 per child ❑ None

List family members you are enrolling for life insurance coverage (attach a sheet with additional dependent life insurance information):

Last name	First	MI	Sex	Birthdate	Social Security No.	Relationship (spouse/child)

Beneficiary Designation for Life Insurance *You may name one, two or more beneficiaries. If you have additional beneficiaries, attach a sheet with the additional names, addresses and designate beneficiaries as primary or contingent.*

❑ Primary ____
Last name First MI Relationship Birthdate

❑ Contingent ____
Last name First MI Relationship Birthdate

5. LONG TERM DISABILITY

A. All eligible members will be covered at 60% of their base salary to a maximum of $5,000 per month.

6. SIGNATURE

My signature below indicates that I have read and understand the election form and descriptive materials provided. This enrollment form is binding on me and cannot be revoked or modified, except as explained in the descriptive materials provided. I also understand that my salary will be reduced by the amount required (if any) for the benefits I have elected.

I authorize my insurance carriers or Health maintenance Organization (HMO) to obtain, examine or release any medical, vision or dental records or other information needed to coordinate benefits or process claims for me and my family members. I declare that the dependents listed on this form are mine or my domestic partner's legal dependents. I declare that the information furnished on this form to be true, correct and complete to the best of my knowledge.

I also authorize any provider having knowledge of my medical history or my dependents to release to my insurance carriers or HMO any medical information it requests. I authorize my insurance carriers or HMO to share such medical information with me or my dependents' health care providers.

Employee's signature ____ Date ____________________