2020 Enrollment / Change Form

Human Resources Use Only

EMPLID: _____

☐ New enrollment: Dental/Vision Effective Date: _____

PS Entered: _____

☐ Change in coverage Life/AD&D/STD/LTD Effective Date: _____

a. reason for change: _____

b. date if change in status:

Termination date: _____ ☐ Part-time: _____

Employee Information (please print)

Last Name		First Name	Middle Initial	
Employee #	Social Security #	Birthdate	Sex	
Street Address		City	State	Zip
Marital Status/Date	Spouse name	Spouse birthdate	Phone number (home)	

Benefits Selections

For each plan, check your selected options:

* 1. Dental

☐ PPO (Delta Dental of Washington)
☐ DMO (Delta Care-Delta Dental of Washington)
☐ DMO (Willamette Dental)
☐ No coverage

Coverage Level

☐ Participant only
☐ Participant and Spouse
☐ Participant and Child(ren)
☐ Participant, Spouse and Child(ren)

* 2. Vision

☐ Basic (VSP)
☐ Enhanced (VSP)
☐ No coverage

Coverage Level

☐ Participant only
☐ Participant and Spouse
☐ Participant and Child(ren)
☐ Participant, Spouse and Child(ren)

* 3. Term Life Insurance

Check the box for the total coverage requested; refer to rules located on SharePoint

You must at a minimum enroll in the first Employee option of $25,000.

Employee

☐ $25,000 Core

Supplemental (in addition to core)

☐ $50,000 ☐ $75,000
☐ $100,000 ☐ $125,000
☐ $150,000 ☐ $175,000
☐ $200,000 ☐ $225,000
☐ $250,000 ☐ $275,000
☐ $300,000 ☐ $325,000
☐ $350,000 ☐ $375,000
☐ $400,000 ☐ $425,000
☐ $450,000 ☐ $475,000
☐ $500,000

(No EOI required if enrolling as New Hire)

Spouse: New hires can enroll their spouses in $12,500 or $25k with no EOI. Can't exceed employee's own amount.

Supplemental

☐ $12,500
☐ $25,000

EOI Required for below amounts

☐ $50,000 ☐ $75,000
☐ $100,000 ☐ $125,000
☐ $150,000 ☐ $175,000
☐ $200,000 ☐ $225,000
☐ $250,000 ☐ $275,000

☐ No coverage

Child(ren)

☐ $2,500
☐ $5,000
☐ $7,500
☐ $10,000
☐ No coverage

4. AD&D Insurance

Choose one option (cannot exceed $500,000 maximum plan limit)

☐ Employee only
☐ Employee & family
☐ No coverage

Amount of Employee Coverage $ _____

Please Note:
Coverage must be in increments of $10,000. Family Coverage is calculated as a percentage of employee coverage.

5. Short-Term Disability

Cost is for employee-only coverage for up to 60 days. Pays 60% of employee's salary (capped at $100,000 base salary).

☐ 7 day waiting period ☐ 30 day waiting period ☐ No coverage

6. Long-Term Disability

Cost is for employee-only coverage after 60 days. 40% option is capped at $180,000 base salary; 60% option is capped at $200,000 base salary.

☐ 40%/60 day waiting period ☐ 60%/60 day waiting period ☐ No Coverage

REMINDER: If you waive, or select a lower option, for Short and/or Long Term Disability, you cannot increase coverage without first obtaining approval from the carrier (via the Evidence of Insurability process)

* Paid on a pre-tax basis

Family Members to be Enrolled

SPOUSE

Last name	First name	Middle initial	Social Security Number
Street address (if different than employee)	City	State	Zip
Birth date	Sex	Relationship to you	

CHILD

Last name	First name	Middle initial	Social Security Number
Street address (if different than employee)	City	State	Zip
Birth date	Sex	Relationship to you	

CHILD

Last name	First name	Middle initial	Social Security Number
Street address (if different than employee)	City	State	Zip
Birth date	Sex	Relationship to you	

CHILD

Last name	First name	Middle initial	Social Security Number
Street address (if different than employee)	City	State	Zip
Birth date	Sex	Relationship to you	

Beneficiary Designation

Make your beneficiary designation for Term Life Insurance and AD & D Insurance (If trust or will listed – name of trustee or executor required)

PRIMARY

1. Last name	First name	Middle initial
Social Security Number	Date of Birth	% designation / Relationship
2. Last name	First name	Middle initial
Social Security Number	Date of Birth	% designation / Relationship

SECONDARY

1. Last name	First name	Middle initial
Social Security Number	Date of Birth	% designation / Relationship
2. Last name	First name	Middle initial
Social Security Number	Date of Birth	% designation / Relationship

Pre-tax Waiver (Optional)

Contact Human Resources if you would like to complete a pre-tax waiver to have your premiums deducted after taxes.

Employee Authorization

REQUIRED

I understand that I have made an election for my benefits package for the plan year. Any choices I have made may only be altered as the result of a change in family status as defined in the plan or if an IRS ruling affects the plan. I also understand that any unused amounts in either spending account will be forfeited after the end of the year. I agree to have my benefits contributions deducted from my pay on a before-tax basis (for specified before-tax benefits) unless I have signed the waiver box above. I authorize all health care providers, claim processing agents, insurance and reinsurance agencies or other persons or organizations performing direct administrative professional, medical, or legal services or care in connection with my claims to disclose any information necessary for investigation, evaluation, or payment of a claim. I understand that reasonable efforts will be made to use, disclose, and request only the minimum amount of information needed to accomplish the intended purpose of the use, disclosure, or request. I further verify that the information I have furnished is correct.

Employee Signature _____ Date _____