



Combined insurance enrollment form

Complete entire form to enroll or make changes.

Employer – Please note that failure to fully complete this form may result in this form being returned to you and will delay the processing of the form. Please proof this form carefully.

Employer

Employer to complete this section and send completed form to AWC at benefitinfo@awcnet.org or fax to 360.753.0149 or mail to 1076 Franklin Street SE, Olympia, WA 98501-1346

Employer name

Date of hire

Effective date of change

City of DuPont

Employee's occupation

Class/bargaining unit

Salary Annual \$ _____

Monthly \$ _____

Weekly \$ _____

Hourly \$ _____

Enrollment

Changes

Has there been a change that affects your insurance? Check **all the changes** that apply to you **and complete the entire form.**

- New hire
- New group
- Open enrollment
January 1

- Name Address Marriage Domestic Partnership Divorce Legal separation Beneficiary

Other (be specific) _____

- Add dependent (check reason) Marriage Domestic Partnership Newborn
- Other reason (be specific) _____

Drop dependent Comments _____

Employee

Please print legibly in blue or black ink.

SSN

Employee name (last, first, initial)

Date of birth

Gender

Single

Married

Divorced Date divorced: _____

Partnership termination

Partnership termination date: _____

Mailing address

Phone (with area code)

City

State

Zip

Email address

Type of coverage requested (check all that apply):

- Medical
- Dental
- Vision
- Life
- Long-term disability
- EAP

Carriers and specific plans are listed on the back of this form.

Are you adding this coverage due to a recent loss of coverage?

Yes No If yes, complete below.

Name of other insurance company

Type of insurance (medical, dental, etc.)

Group#

Policy #

Effective date

Termination date

Insured's SSN

Name (last, first, initial)

Spouse/ Domestic Partner

Please list spouse/domestic partner who should be covered on your insurance. Leaving them off will terminate coverage. Proof of dependency will be requested, including, but not limited to, marriage certificate, affidavit of marriage/domestic partnership, joint ownership documents.

SSN	Spouse/DP name (last, first, initial)	Date of birth	Gender
-----	---------------------------------------	---------------	--------

Date married: _____ Date met DP criteria: _____

Type of insurance requested: Medical Dental Vision Life

Are you adding this coverage due to a recent loss of coverage? Yes No If yes, complete below.

Name of insurance company	Type of insurance (medical, dental, etc.)	Group#	Policy #
---------------------------	---	--------	----------

Effective date	Termination date	Phone #
----------------	------------------	---------

Dependents

Please list all dependents that should be covered on your insurance. Leaving them off the form will terminate coverage. Proof of dependency will be requested, but not limited to, birth certificate, adoption papers. **Medical, dental & vision:** A dependent is a child, stepchild or adopted child; less than age 26 or prior to age 26 was incapable of self-support due to developmental disabilities or physical handicap (proof of incapacity required). **Life:** A dependent is a child, stepchild or adopted child from birth but less than age 26.

**Please check all appropriate boxes and fill in the appropriate blanks.
For additional dependents, please fill out additional forms and alter "Dependent # _____."**

Dependent #1

Name (last, first, middle initial)

SSN _____

Gender _____ Date of birth _____ Relationship to insured _____

Type of insurance requested:

Medical Dental Vision Life

Are you adding this coverage due to a recent loss of coverage? Yes No

If yes, name of other insurance company & type (medical, dental, etc.)

Name of insured (last, first, initial) _____ SSN of insured _____

Group/policy # _____ Effective date _____ Termination date _____

Does he/she live with you? Yes No

Mailing address _____ Home phone _____

City _____ State _____ Zip _____

Dependent #2

Name (last, first, middle initial)

SSN _____

Gender _____ Date of birth _____ Relationship to insured _____

Type of insurance requested:

Medical Dental Vision Life

Are you adding this coverage due to a recent loss of coverage? Yes No

If yes, name of other insurance company & type (medical, dental, etc.)

Name of insured (last, first, initial) _____ SSN of insured _____

Group/policy # _____ Effective date _____ Termination date _____

Does he/she live with you? Yes No

Mailing address _____ Home phone _____

City _____ State _____ Zip _____

Dependents

Please list all dependents that should be covered on your insurance. Leaving them off the form will terminate coverage. Proof of dependency will be requested, but not limited to, birth certificate, adoption papers. **Medical, dental & vision:** A dependent is a child, stepchild or adopted child; less than age 26 or prior to age 26 was incapable of self-support due to developmental disabilities or physical handicap (proof of incapacity required). **Life:** A dependent is a child, stepchild or adopted child from birth but less than age 26.

**Please check all appropriate boxes and fill in the appropriate blanks.
For additional dependents, please fill out additional forms and alter "Dependent # _____".**

Dependent #3			Dependent #4		
Name (last, first, middle initial)			Name (last, first, middle initial)		
SSN			SSN		
Gender	Date of birth	Relationship to insured	Gender	Date of birth	Relationship to insured
Type of insurance requested: <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Life			Type of insurance requested: <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Life		
Are you adding this coverage due to a recent loss of coverage? If yes, name of other insurance company & type (medical, dental, etc.)			Are you adding this coverage due to a recent loss of coverage? If yes, name of other insurance company & type (medical, dental, etc.)		
Name of insured (last, first, initial)		SSN of insured	Name of insured (last, first, initial)		SSN of insured
Group/policy #	Effective date	Termination date	Group/policy #	Effective date	Termination date
Does he/she live with you? <input type="checkbox"/> Yes <input type="checkbox"/> No			Does he/she live with you? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Mailing address		Home phone	Mailing address		Home phone
City		State	City		State

Employee plan enrollment (Please check all that apply.)

Medical



1111 Lake Washington Blvd N.

Suite 900

Renton, WA 98057

Regence BlueShield

High Deductible Health Plan



2715 Naches Ave. SW

Renton, WA 98057

Kaiser Foundation Health Plan of Washington Options, Inc.

Access PPO

Decline medical coverage

Vision



3333 Quality Drive

Rancho Cordova, CA 95670

Vision Service Plan (071038Z2)

No copay

Second pair rider

Dental



Delta Dental of Washington

400 Fairview Ave N

Seattle, WA 98109-5371

Delta Dental of Washington

Basic (0177)

Plan E

Orthodontia

Option II



6950 NE Campus Way

Hillsboro, OR 97124

Willamette Dental of Washington, Inc.

\$10 copay

Life



1100 SW 6th Ave

Portland, OR 97204

Standard Insurance Company

Basic life w/AD&D

\$ _____

Employee additional life

\$ _____

Note: EOI form required if over \$80,000.

Spouse additional life

\$ _____

Note: EOI form required if over \$20,000.

Employee Assistance Program



NBC Tower

455 N. Cityfront Plaza Drive

Chicago, IL 60611-5322

ComPsych

1-6 sessions - Included when enrolled on any AWC Trust plan

Long-term disability



1100 SW 6th Ave

Portland, OR 97204

Standard Insurance Company

90-day: 60% benefit