WASHINGTON STATE COUNCIL OF FIRE FIGHTERS
MEDICAL EXPENSE REIMBURSEMENT PLAN
Administered by Benefit Solutions, Inc.
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Washington State
Council of Fire Fighters

Enrollment Application

Check One: ☐ First Enrollment ☐ Dependent Change ☐ Address Change ☐ Name Change

PERSONAL INFORMATION: ***Please Print Clearly***

Member Name:				- -
	Last	*First*	*MI*	Social Security Number
Address:				
City:		State:	Zip:	Effective Date:
Phone:		Email:		
Gender: ☐M ☐F	Date of Birth:	Marital Status:	Date of Marriage/Divorce:	

FAMILY MEMBER INFORMATION:

Full Name	Birthdate	Relationship to Employee	Gender	SSN	
1).		☐ Spouse ☐ Domestic Partner	☐ M ☐ F	- -	☐ Add ☐ Delete
2).			☐M ☐F	- -	☐ Add ☐ Delete
3).			☐M ☐F	- -	☐ Add ☐ Delete
4).			☐M ☐F	- -	☐ Add ☐ Delete
5).			☐M ☐F	- -	☐ Add ☐ Delete
6).			☐M ☐F	- -	☐ Add ☐ Delete

***If you have additional dependents, you may list them on the back of this application.**

Pursuant to the confirmation election of my local union, my employer will contribute an amount as specified in the local's collective bargaining agreement on my behalf to the WSCFF Medical Expense Reimbursement Plan.

Participant Signature: _____ **Date:** _____

Internal Use Only:

Employer Name: **Bothell Professional Fire Fighters Association** *Employer Billing Number:* **49**

Date Received: _____ *Date Processed:* _____ *Initials:* _____