Administered by Vimly Benefit Solutions, Inc.
P.O. Box 6, Mukilteo, WA 98275
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Northwest Fire Fighters NWFF Benefits Trust

BOTHELL FIRE FIGHTERS
2020 ACTIVE ENROLLMENT FORM

Check One:	☐ Open Enrollment ☐ New Employee ☐ Address Change ☐ Name Change ☐ Family Member Change ☐ Other				
PERSONAL INFORMATION: ***Please Print Clearly***					
Member Name:	*Last* *First* *MI*				- - Social Security Number
Address:					
City:		State:	Zip:	Effective Date:	Date of Hire:
Phone: ( )	Date of Birth:	Marital Status:	Date of Marriage/Divorce:	Gender ☐M ☐F	

Please Indicate Employment Status:

☐ **LEOFF 1** ☐ **LEOFF 2** ☐ **PERS**
☐ **Other, Please Specify:**_____

MEDICAL PLAN – Regence BlueShield

Plan $1500
Coverage underwritten by Regence BlueShield: 1800 Ninth Avenue Seattle, WA 98101

DENTAL PLANS – Delta Dental of Washington

You and any dependents listed below will be enrolled in the following Dental Plan through the Northwest Fire Fighters Benefits Trust:
No Dental

You are committed to your plan selections for the 2019 Plan Year.
You will have the opportunity to make a change during the next open enrollment period for the 2020 Plan Year OR if you have a Qualifying Change of Status (marriage, birth, divorce, etc.).

FAMILY MEMBER ENROLLMENT: List below any family members you wish to cover. If you are changing the status of your family members, please mark the ADD or DELETE boxes accordingly**.**
Please note: Family member Social Security Numbers are required!

Name of Family Member	Birthdate	Relationship to Member/ Employee	Gender	SSN	
			☐M ☐F	- -	☐ Add ☐ Delete
			☐M ☐F	- -	☐ Add ☐ Delete
			☐M ☐F	- -	☐ Add ☐ Delete
			☐M ☐F	- -	☐ Add ☐ Delete

FAMILY MEMBER ENROLLMENT *Continued*: List below any family members you wish to cover. If you are changing the status of your family members, please mark the ADD or DELETE boxes accordingly.

Please note: Family member Social Security Numbers are required!

Name of Family Member	Birthdate	Relationship to Member/ Employee	Gender	SSN	
			☐M ☐F	- -	☐ Add ☐ Delete
			☐M ☐F	- -	☐ Add ☐ Delete
			☐M ☐F	- -	☐ Add ☐ Delete

THIS ENROLLMENT FORM IS NOT VALID UNLESS IT IS SIGNED AND DATED

* Please note that the IRS does not treat domestic partners as legal dependents. Therefore, you will be taxed on a portion of the employer's contribution, as reflecting the value of the medical, dental, and vision coverage provided to the domestic partner, as required by IRS regulations.

COORDINATION OF BENEFITS: If you or any family members currently have other group medical or dental coverage (including Medicare), please complete below:

Medical	Dental	Name of Family member	Name of Insurance and /or Policyholder Name	Date coverage began	Date coverage ended	Medicare List A, B or Both	Plan Number or Medicare HIC #
☐	☐						
☐	☐						
☐	☐						

Enrollment information that I previously submitted for a specific insurance plan is superseded by changes indicated on this form. By signing below, I acknowledge that I wish to enroll myself and my family members in the medical/dental plan coverage as indicated on the front of this form and that my employer may deduct applicable premiums from my payroll. I certify that the family members enrolled on this form meet the definition of Eligible Family Member, as defined in Plan Certificate of Coverage and incorporated into the "Enrollment Guide of the Northwest Fire Fighters Benefits Trust".

By signing below, I declare that the information on the Enrollment Application is true, correct, and complete to the best of my knowledge, and that I have read and understand the Enrollment Application and Enrollment Guide covering the options provided under the plan. I authorize the Trust's insurance carriers and administrators to obtain, examine or release information needed to coordinate benefits or process claims for me or my family. I understand that it is a crime to knowingly provide false, incomplete, or misleading information to an insurance company. Penalties include imprisonment, fines and denial of insurance benefits.

_____ Signature

_____ Date

_____ Print Name

_____ Email Address

Please return form to the Trust Office at:

Vimly Benefit Solutions

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