GROUP BENEFIT ENROLLMENT & CHANGE FORM	New Employee ☐ Open Enrollment ☐	Change of Status ☐ Describe:

Washington Counties Insurance Fund, Attention to: Zenith Administrators, 201 Queen Anne Avenue North, Ste 100, Seattle, WA 98109

Work Location/County:	Employer Name: Whatcom County	Department:	Work Phone:
			Birthdate:
Last Name:	First Name:	Initial:	SSN:
			Married ☐ Single ☐
Home Address: (Street) (City) (State) (Zip)			Telephone:
			Male ☐ Female ☐
Marriage Date:	Date Hired Full Time:	Hours Worked/Week:	

I wish to apply for the following benefit plans:

DENTAL: [ ] WASHINGTON DENTAL PLAN 049___-_____

[ ] VISION SERVICE PLAN Div No_____

[ ] Standard BASIC LIFE _____ Annual Salary $_____ (If applicable)

I wish to obtain benefit coverage for the following: [ ] MYSELF [ ]MYSELF AND ELIGIBLE DEPENDENTS (List all eligible dependents below)

LAST NAME	FIRST NAME	MI	SEX M/F	RELATIONSHIP	SSN	BIRTHDATE	BENEFIT COVERAGE		
							DENTAL	VISION	BASIC LIFE

In the event of my death all proceeds from my life insurance shall be paid to:

Primary Beneficiary (Full Name and Address)	Relationship	Soc. Sec. #
Secondary Beneficiary (Full Name and Address)	Relationship	Soc. Sec. #

I understand that I am responsible for notifying my Employer of changes in my marital and/or dependent status. I apply for coverage as indicated above and contracted for by the Washington Counties Insurance Fund and I further agree to abide by the terms of such insurance contracts. I also apply for coverage for my family as listed above and hereby authorize my employer to deduct any applicable premiums from my pay as required by such contract. I further agree and authorize the insurance carriers or their agents to examine any provider or carrier records, including Title XVII Medicare, concerning me or my family as necessary for the processing of insurance claims.

I have read and understand the above statement and agree to its terms	**For payroll use only:** **Effective date of coverage:**

Rev 09/08 (Signature of Employee/Member) (Date Signed)