



Western Healthcare Insurance Trust

Email: KFuller@BSITPA.com Phone: (206)859-2674 Fax: (206) 859-2627

Return Form To: PO Box 6 Mukilteo WA 98275

Employee Enrollment/Change Form

**WHIT Account
Number**

Please mark all boxes that apply and return to your Human Resources Department.

APPLICANT	Employer Name		<input type="checkbox"/> New <input type="checkbox"/> Change <input type="checkbox"/> Termination <input type="checkbox"/> Qualifying Event <input type="checkbox"/> Waive			Date of Hire	Effective Date
	SSN	Last Name		First Name		Date of Birth	
	Address			City	State	Zip	Gender M <input type="checkbox"/> F <input type="checkbox"/>
DEPENDENTS	Spouse/DP	SSN	Last Name	First Name	Date of Birth	Gender M <input type="checkbox"/> F <input type="checkbox"/>	Add Term <input type="checkbox"/> <input type="checkbox"/>
	Dependent	SSN	Last Name	First Name	Date of Birth	Gender M <input type="checkbox"/> F <input type="checkbox"/>	Add Term <input type="checkbox"/> <input type="checkbox"/>
	Dependent	SSN	Last Name	First Name	Date of Birth	Gender M <input type="checkbox"/> F <input type="checkbox"/>	Add Term <input type="checkbox"/> <input type="checkbox"/>
	Dependent	SSN	Last Name	First Name	Date of Birth	Gender M <input type="checkbox"/> F <input type="checkbox"/>	Add Term <input type="checkbox"/> <input type="checkbox"/>
	Dependent	SSN	Last Name	First Name	Date of Birth	Gender M <input type="checkbox"/> F <input type="checkbox"/>	Add Term <input type="checkbox"/> <input type="checkbox"/>
	Dependent	SSN	Last Name	First Name	Date of Birth	Gender M <input type="checkbox"/> F <input type="checkbox"/>	Add Term <input type="checkbox"/> <input type="checkbox"/>
BENEFICIARY	This designation applies to Life Insurance available through your Employer, if any. Designations are not valid unless signed, dated and delivered to the employer during your lifetime.						
	Primary- Full Name		Address		SSN	Relation	% of Benefit
	Contingent- Full Name						
The undersigned understands that it is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purposes of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.							
Employee Signature (Required)				Date Signed			

CARRIERS	Dental		Vision		Basic Life/AD&D, LTD & STD
	Washington Dental Service 9706 4 th Ave NE Seattle, WA 98115	Willamette Dental of Washington Inc 6950 NE Campus Way Hillsboro, OR 97124	Vision Service Plan 333 Quality Drive Rancho Cordova, CA 95670		Standard Insurance Company 1100 SW 6 th Ave Portland, OR 97204

Human Resources	Please check the boxes applicable to your company to indicate which coverage(s) your employee is enrolling in.					
	PLEASE NOTE: Voluntary Life and LTD buy up coverages must be applied for using The Standard's enrollment application.					
	Dental <i>Please check one</i>	Dental Buy Up? <i>Please check one</i>	Vision <i>Please check one</i>	Basic Life/ AD&D <i>Please check one</i>	LTD <i>Please check one</i>	STD <i>Please check one</i>
	Washington Dental Service <input type="checkbox"/>	YES <input type="checkbox"/>	YES <input type="checkbox"/>	YES <input type="checkbox"/>	YES <input type="checkbox"/>	YES <input type="checkbox"/>
	Willamette Dental <input type="checkbox"/>	NO <input type="checkbox"/>	NO <input type="checkbox"/>	NO <input type="checkbox"/>	NO <input type="checkbox"/>	NO <input type="checkbox"/>
	Annual Salary (Only needs to be completed if employee is opting for life or disability coverages) \$ _____					
Employee Class as it pertains to life or disability coverages:						
Employer-Please retain a copy of this document for your records and send the completed form to one of the addresses above.						