Administered by Welfare & Pension Administration Service, Inc.
P.O. Box 34203 • Seattle, WA 98124-1203
Phone (888) 563-0665 • Fax (206) 505-9727

Date of Hire	
Effective Date:	

SPOKANE FIRE FIGHTERS BENEFIT TRUST

PLEASE PRINT

2023 ENROLLMENT FORM

A COMPLETED ENROLLMENT FORM MUST BE ON FILE IN THE ADMINISTRATION OFFICE FOR YOU AND YOUR DEPENDENTS BEFORE ANY CLAIMS CAN BE PROCESSED. ***It is necessary to attach copies of your marriage certificate to enroll your spouse/registered domestic partner, and birth certificates for any children you wish to cover.*** **SEE PAGE 2 OF FORM FOR DEFINITION OF ELIGIBLE DEPENDENTS.**

☐ Open Enrollment ☐ New Member ☐ Add/Delete Dependent(s)
☐ Name Change: _____ ☐ Address Change ☐ Other _____ *(please specify)*
(Maiden Name)

MEMBER NAME (Last, First, Middle Initial)	SOCIAL SECURITY NUMBER	SEX	BIRTHDATE (Mo/Day/Year)

Marital Status
☐ Single ☐ Married ☐ Divorced ☐ Widowed

Date of Marriage/Divorce (Mo/Day/Year)

Mailing Address (Street or PO Box, City, State, Zip Code)

Phone Number

Email Address

Please Indicate Employment Status:
☐ Spokane FF ☐ SIA ☐ SAFO ☐ Other *(please specify):*

MEDICAL PLAN – Premera Blue Cross – Classic $1500

Please Choose One:

☐ **Employee Only** ☐ **Employee &Child** ☐ **Employee & Spouse &Child**
☐ **Employee & Spouse** ☐ **Employee &Children** ☐ **Employee & Spouse &Children**

DENTAL PLANS – Delta Dental of Washington

If you enroll in either medical plan, you (and any dependents) will automatically be enrolled in the Delta Dental of Washington Plan. Coverage underwritten by Delta Dental of Washington: 9706 4th Avenue NE • Seattle, WA 98115-2157

You are committed to your plan selection for the 2023 Plan Year. You will have the opportunity to make a change during the next open enrollment period for the 2024 Plan Year or if you have a Qualifying Change of Status (marriage, birth, divorce, etc.).

FAMILY MEMBER ENROLLMENT

NAME (Last, First, Middle Initial)	SSN	SEX	BIRTHDATE (Mo/Day/Year)	RELATIONSHIP	☑ Step Child
					☐
					☐
					☐
					☐

COORDINATION OF BENEFITS

Are you, your spouse/registered domestic partner, or other dependents covered by any other group medical, dental or vision plan including Medicare?

☐ Yes ☐ No If "yes," please provide the information requested. If Medicare, copy of Medicare ID card must be on file with the Administration Office.

Name of Subscriber with Other Coverage Soc Sec Number

Name of other Insurance Company Policy or I.D. Number

Address of other Insurance Company City State Zip

1. Insurance covers: ☐ Subscriber ☐ Spouse/Registered Domestic Partner ☐ Children
2. Coverage includes: ☐ Medical ☐ Dental ☐ Vision

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 indicted 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 stated below and incorporated into the "Summary Plan Description of the Spokane Fire Fighters Benefits Trust."

By signing below, I declare that the information on the Enrollment Form is true, correct, and complete to the best of my knowledge, and that I have read and understand the Enrollment Form and Enrollment Guide covering the options provided under the plan. It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits. 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 I may be subject to disciplinary action and/or repayment of any claims paid by my health plan, or contributions paid or remitted by the Spokane Fire Fighters Benefits Trust if I have provided false, incomplete, or misleading information, or fail to update this information in accordance with eligibility rules set by the Trust.

I hereby certify that the above information is true, correct and complete to the best of my knowledge. **ATTACHED ARE TRUE COPIES OF OUR APPROPRIATE MARRIAGE CERTIFICATES, BIRTH CERTIFICATES, COURT-APPROVED ADOPTION OR LEGAL GUARDIANSHIP DOCUMENTATION.** The above information will be used to determine eligibility for claim/benefit purposes.

Member Signature	Print Name	Date

(must be signed by participating member)

Please return form to the Trust Office at:
Welfare & Pension Administration Service, Inc.
P.O. Box 34203 • Seattle, Washington 98124
Phone (888) 563-0665 • Fax (206) 505-9727
Or scan and email to: enrollment@wpas-inc.com

NOTICE

Please be advised that this form MUST be signed by the participating Member for beneficiary designations to be valid.

ELIGIBLE MEMBERS

A full-time, active LEOFF II with established LEOFF II membership, AND regularly scheduled to work a minimum of 30 hours per week for the City of Spokane Fire Department, AND Non-Bargained Administrative Support employees of IAFF Locals working a minimum of 20 hours per week.

Dependent eligibility is determined by your hours worked. Check with the Administration Office if you have questions on eligibility.

Your eligible dependents are your legal spouse/registered domestic partner and any child under age twenty-six (26).

ELIGIBLE SPOUSES/REGISTERED DOMESTIC PARTNERS

- Legal Spouse of an Active or Retired LEOFF I or LEOFF II member, which includes the legally formed marriage of two persons validly formed in any jurisdiction in the United States or in a foreign jurisdiction that is recognized under Washington Law.
- Surviving Spouse of a deceased member (not divorced) who was enrolled for active or retiree coverage at the time of death or is a surviving member of a LEOFF I member who was enrolled for coverage in the Plan prior to the death of the LEOFF I member.
- Domestic Partner registered pursuant to state law or domestic partners who have signed and meet all the requirements of the affidavit of Domestic Partnership established by the Trust.

ELIGIBLE CHILDREN

- A covered participant's natural child as shown on the birth certificate.
- Legally adopted child:
  - A minor child placed with you for the purpose of legal adoption will be covered from the moment the child is placed in your custody.
  - The child's coverage will continue until the earlier of:
    - the day the child is removed from your custody prior to legal adoption; or
    - the day coverage would otherwise end in accordance with the plan provisions.
- A child for whom the participant has a court order establishing a legal obligation for coverage.
- A natural or adopted child of the spouse/registered domestic partner of a covered participant.