

Enrollment information that I previously submitted for a specific insurance plan is superseded by changes indicated on this form.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 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
(*must be signed by participating member*)

Print Name

Date

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.