



**WESTERN HEALTHCARE INSURANCE TRUST (WHIT)**  
 Email: [WHIT@BSITPA.com](mailto:WHIT@BSITPA.com) Phone: (206) 859-2600 Fax: (206) 859-2627  
 Return Form To: PO Box 6 Mukilteo WA 98275

**WHIT Account  
Number**

**Employee Enrollment/Change Form**

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

<b>EMPLOYER</b>	Group Name			Employee Date of Hire:	Effective Date:	Salary:	Employee Billing Class:				
	ENROLLMENT (check one): <input type="checkbox"/> New Employee <input type="checkbox"/> Open Enrollment <input type="checkbox"/> Status Change			Enrollment/Change Reason: (circle one) Marriage, divorce, birth, adoption, death, involuntary loss of coverage, change in class, court order, or other _____				Date of Event:			
<b>EMPLOYEE</b>	Home Address:			City	State	Zip	Home Phone				
	<b>ADD</b>	<b>DROP</b>	<b>Relationship to Employee</b>	<b>Last Name</b>	<b>First Name</b>	<b>SSN</b>	<b>Date of Birth</b>	<b>Gender</b>			
	<input type="checkbox"/>	<input type="checkbox"/>	Employee					<b>M</b>	<b>F</b>		
	<input type="checkbox"/>	<input type="checkbox"/>	Spouse/Domestic Partner								
	<input type="checkbox"/>	<input type="checkbox"/>									
	<input type="checkbox"/>	<input type="checkbox"/>									
	<input type="checkbox"/>	<input type="checkbox"/>									
	<input type="checkbox"/>	<input type="checkbox"/>									
<b>BENEFICIARY</b>	This designation applies to Basic Life / Basic Life with AD&D Insurance available through your Employer, if any. Designations are not valid unless signed, dated and delivered to the employer during your lifetime.										
	<b>Primary- Full Name</b>			<b>Relation</b>	<b>Address</b>			<b>SSN</b>	<b>% of Benefit</b>		
<b>Contingent- Full Name</b>			<b>Relation</b>	<b>Address</b>			<b>SSN</b>	<b>% of Benefit</b>			
<b>COVERAGES</b>	) <b>Dental</b> ‡ 9706 4 <sup>th</sup> Ave NE Seattle, WA 98115		Dual Choice <input type="checkbox"/> Group# _____	Employee Only <input type="checkbox"/>	Employee + Spouse <input type="checkbox"/>	Employee + Child(ren) <input type="checkbox"/>	Employee + Family <input type="checkbox"/>	Decline <input type="checkbox"/>			
	<b>Willamette Dental of Washington, Inc.</b> 6950 NE Campus Way Hillsboro, OR 97124			Employee Only <input type="checkbox"/>	Employee + Spouse <input type="checkbox"/>	Employee + Child(ren) <input type="checkbox"/>	Employee + Family <input type="checkbox"/>	Decline <input type="checkbox"/>			
	<b>Superior Vision</b> 1101 White Rock Rd Rancho Cordova, CA 95670			Employee Only <input type="checkbox"/>	Employee + Spouse <input type="checkbox"/>	Employee + Child(ren) <input type="checkbox"/>	Employee + Family <input type="checkbox"/>	Decline <input type="checkbox"/>			
	<b>Vision Service Plan</b> 333 Quality Drive Rancho Cordova, CA 95670			Employee Only <input type="checkbox"/>	Employee + Spouse <input type="checkbox"/>	Employee + Child(ren) <input type="checkbox"/>	Employee + Family <input type="checkbox"/>	Decline <input type="checkbox"/>			
	<b>The Standard</b> 1100 SW 6 <sup>th</sup> Ave Portland, OR 97204		Basic Life <input type="checkbox"/> Class _____	Basic Dep Life <input type="checkbox"/>	LTD <input type="checkbox"/> Buy Up <input type="checkbox"/> Class _____	STD <input type="checkbox"/> Class _____	Voluntary Life or ADD <input type="checkbox"/> The Standard's Enrollment Form must be completed to apply for this coverage.				
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.							<b>Employee Signature &amp; Date (Required)</b>				