



WESTERN HEALTHCARE INSURANCE TRUST (WHIT)
 Email: WHIT@Vimly.com Phone: (206) 859-2600 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.

EMPLOYER	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:			
EMPLOYEE	Home Address:			City	State	Zip	Home Phone				
	ADD	DROP	Relationship to Employee	Last Name	First Name	SSN	Date of Birth	Gender			
									M	F	
	<input type="checkbox"/>	<input type="checkbox"/>	Employee								
	<input type="checkbox"/>	<input type="checkbox"/>	Spouse/Domestic Partner								
	<input type="checkbox"/>	<input type="checkbox"/>									
	<input type="checkbox"/>	<input type="checkbox"/>									
BENEFICIARY	This designation applies to Life / 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.										
	Primary- Full Name			Relation		Address			SSN		% of Benefit
	Contingent- Full Name			Relation		Address			SSN		% of Benefit
COVERAGES	Washington Dental Service 9706 4 th 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"/>			
	Willamette Dental of Washington, Inc. 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"/>			
	Vision Service Plan 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"/>			
	The Standard 1100 SW 6 th 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.							Employee Signature & Date (Required)				