

**WASHINGTON STATE COUNCIL OF COUNTY AND CITY EMPLOYEES
HEALTH AND WELFARE TRUST**

ENROLLMENT FORM

PLEASE PRINT

F36

<input type="checkbox"/> New Member <input type="checkbox"/> Address Change <input type="checkbox"/> Add Dependents <input type="checkbox"/> Name Change _____ <div style="text-align: right; font-size: small;">previous name</div>
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Employee Name (Last, First, M.I.)	Employee Social Security No.	Birth Date (Mo/Day/Yr)	Sex <input type="checkbox"/> M <input type="checkbox"/> F
Mailing Address (City, State, Zip)		Phone Number	
Employer Name	Effective Date	Employee E-mail Address	

Dependent Name (Last, First, M.I.)	Social Security Number	Sex	Birth Date (Mo/Day/Year)	Relationship to Subscriber	Check by (x) if Step, Foster or Adopted Child
Spouse/Domestic Partner				Date of Marriage/ Partnership	
Eligible Dependents (see back for definition)					

1. Are you, your spouse, or other dependents covered by any other group dental insurance plan? <input type="checkbox"/> Yes <input type="checkbox"/> No If "yes," please provide the information requested. If more space is needed, please attach as separate sheet.			
Name of Person with Other Coverage	Social Security Number	Policy or I.D. Number	
Name and Address of Other Insurance Company	City	State	Zip
2. Other insurance covers: <input type="checkbox"/> Member <input type="checkbox"/> Spouse/Domestic Partner <input type="checkbox"/> Children			
3. Coverage includes: <input type="checkbox"/> Dental			

I verify that the information above is true and complete to the best of my knowledge.

Signature (*must be signed by participating employee*)

Date

Any questions, please contact the Administration Office at (800) 732-1121

**Please return this form to:
ADMINISTRATION OFFICE
P.O. BOX 34203, SEATTLE, WA 98124-1203**

DEFINITION OF ELIGIBLE DEPENDENT

Eligible Dependents

Only the following are eligible for dependent coverage:

- (a) Your lawful spouse or state registered Domestic Partner (if approved by the Trust);
- (b) Your natural-born or legally adopted child up to age 26;
- (c) Your stepchild who is living in your home and is chiefly dependent on you for support;
- (d) Children of state registered Domestic Partner (if approved by the Trust);
- (e) A foster child; and
- (f) A handicapped child (see below).

When the parents of a child are covered under the Plan as employees or members, the child can be covered as a dependent of each parent.

Handicapped Child

Notwithstanding the above, coverage for a child with a disability, developmental disability, mental illness or mental retardation who is incapable of self-support may be continued after the limiting age and after age 26 without payment of any additional premium if the child:

- (a) is chiefly dependent on You for support; and
- (b) is not capable of self-sustaining employment.

The coverage will continue only if you give the Plan proof of the child's disability:

- (a) no later than 31 days after the child attains the limiting age; and
- (b) thereafter as the Plan may require, but not more often than once every two years.

Dependents Not Eligible

The following are not eligible for dependents coverage:

- (a) Your divorced spouse;
- (b) A child who has been legally adopted by another person shall not be considered an eligible dependent, (coverage ends on the date custody is assumed by the adoptive parents);
- (c) Anyone eligible for coverage under the Plan as an employee or member (unless a Special Husband/Wife Provision is included in the Plan); or
- (d) A child who has attained the limiting age. The limiting age is the child's 26th birthday.