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

ENROLLMENT FORM

PLEASE PRINT **F36**

□ New Member □ Address Change □ Add Dependents □ Name Change ______________________
previous name

Employee Name (Last, First, M.I.)	Employee Social Security No.	Birth Date (Mo/Day/Yr)	Sex □ M □ 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?
   □ Yes □ 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: □ Member □ Spouse/Domestic Partner □ Children

3. Coverage includes: □ 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

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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.