Northwest Center
People of all abilities

Benefit Enrollment Form 2026

☐ New ☐ Change ☐ COBRA

Reason _____
Class

Instructions: this form provides you with the different options you may elect. You should complete this form and return it to Human Resources.

Indicate your benefit choice by checking the box next to the desired benefit options.

Medical benefits administered by Premera Blue Cross.
Dental benefits administered by Delta Dental of Washington.
Vision benefits administered by VSP Vision Care Inc.

Premera Blue Cross #1037147
7001 220th St SW, MS 323 Building 3
Mountlake Terrace, WA 98043

Delta Dental of Washington #00435
400 Fairview Ave N., Suite 800
Seattle, WA 98109-5371

VSP Vision Care Inc. #12084243
3333 Quality Dr
Rancho Cordova, CA 95670

Employee Information			
Employee Name:			
Date of Hire:		Effective Date:	
Address:		Job Title:	
City, State, Zip:		Date of Birth:	
Phone Number:		Gender:	
E-mail Address:			

Health Plan Elections	Employee Only	Employee & Spouse / Domestic Partner	Employee & Child(ren)	Employee & Family	Waive
Medical Plan *(only check one)*					
Premera Blue Cros PPO Health Savings Plan	☐	☐	☐	☐	☐
Premera Blue Cross PPO Traditional Plan	☐	☐	☐	☐	☐
Dental and Vision Plans					
Delta Dental of WA – Dental Plan	☐	☐	☐	☐	☐
VSP – Vision Plan	☐	☐	☐	☐	☐

Dependent Information

Check One		Dependent's Name			Date of Birth	Social Security #	Relationship	Gender
Add	Delete	First	MI	Last				
☐	☐						☐ Spouse / DP ☐ Child	☐ Male ☐ Female
☐	☐						☐ Spouse / DP ☐ Child	☐ Male ☐ Female
☐	☐						☐ Spouse / DP ☐ Child	☐ Male ☐ Female
☐	☐						☐ Spouse / DP ☐ Child	☐ Male ☐ Female
☐	☐						☐ Spouse / DP ☐ Child	☐ Male ☐ Female

If any dependents do not reside with you, please list their address:
(*For informational purposes only; dependents are not required to reside with the subscriber.)*

Dependent Name	Address	City	State	Zip

Current/Prior Coverage Information: please indicate for each person listed on this application any health insurance (including Medicare and Medicaid) in effect within the 24 month period prior to the proposed effective date of coverage. Each person applying for coverage must be listed below. If no health insurance coverage was in effect within the past 24 months, please indicate none.

Applicant's Name	Insurance Carrier, Policy Number and Phone Number	Date of Coverage From and To	Will Coverage Continue?	Type of Coverage	Type of Product
			Yes / No	☐ Group ☐ Individual	☐ Medical ☐ Dental
			Yes / No	☐ Group ☐ Individual	☐ Medical ☐ Dental
			Yes / No	☐ Group ☐ Individual	☐ Medical ☐ Dental
			Yes / No	☐ Group ☐ Individual	☐ Medical ☐ Dental
			Yes / No	☐ Group ☐ Individual	☐ Medical ☐ Dental
			Yes / No	☐ Group ☐ Individual	☐ Medical ☐ Dental
			Yes / No	☐ Group ☐ Individual	☐ Medical ☐ Dental

Acknowledgement & Signature

By my signature below, I acknowledge and agree to the following terms and conditions:

- I have been provided with an enrollment packet.
- November is the open enrollment period and my annual opportunity to make any changes to my employee benefit plan elections.
- In accordance with IRS Section 125 rules, I am unable to make changes to my elections until January 1, 2027, unless I or my eligible dependents experience an event that permits a mid-year election change.
- I acknowledge that any persons on this application for coverage are my dependents, as described under the Plan. I agree that falsification of any statement in my application may bar the right to coverage under the Plan. I acknowledge that the information I have provided is true and complete. I further understand that it is my obligation to notify my employer when my spouse, domestic partner or child no longer meets the eligibility requirements described under the Plan. Once a person does not meet the Plan definition of a spouse, domestic partner or dependent child, for example due to divorce, they are no longer eligible for benefits.
- Pre-tax compensation reductions will reduce my taxable income for Social Security purposes and may result in a reduction of Social Security benefits that I, or my dependents, may become entitled to in the future.
- Employees may not pay for domestic partner health insurance premiums with pre-tax dollars unless the partner qualifies as a dependent. In addition, amounts paid by the company for domestic partner coverage are treated as taxable income to the employee.
- I have provided these answers as part of the application procedure required by issuers to enroll in coverage and I acknowledge that all information completed on this form is true, correct, and complete. 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.

______________________________ ______________
Employee Signature **Date**