



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 <i>(only check one)</i>					
Premera Blue Cross 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
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Current/Prior Coverage Information: please indicate for each person listed on this application any health insurance (including Medicare and Medicaid) in effect within the 12 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 12 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
			Yes / No	☐ Group ☐ Individual	☐ Medical ☐ Dental

Acknowledgement & Signature

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

- I received an enrollment packet and reviewed my benefit options.
- November is the annual Open Enrollment period. My elections generally cannot be changed until the next plan year unless I or an eligible dependent experience a qualifying life event that permits a mid-year change.
- I authorize Northwest Center to deduct required benefit premiums from my pay on a pre-tax or post-tax basis, as applicable. Pre-tax deductions reduce my taxable income, including income reported for Social Security purposes, and may slightly reduce future Social Security benefits for me or my dependents.
- If a premium is missed due to insufficient earnings, unpaid leave, or another reason, I remain responsible for payment. Missed premiums may be collected from future paychecks or through another approved payment method.
- Everyone listed on my enrollment is an eligible dependent. I will notify Northwest Center when a dependent is no longer eligible.
- Domestic partner premiums are generally deducted after tax unless the partner qualifies as a tax dependent. Employer-paid domestic partner coverage may be treated as taxable income.
- I acknowledge that all information provided on this form is true, correct, and complete. Knowingly providing false, incomplete, or misleading information may result in denial of insurance benefits and corrective action, up to and including termination of employment. Other penalties may also apply, including fines or imprisonment.

 Employee Signature

 Date