

+Healthcare Benefits Enrollment/Change Form

Snohomish County Human Resources



Instructions

Step 1: Learn about benefit options, make your benefits choices, and complete this form clearly and completely.

- Use this form to enroll in or modify healthcare benefits.
- Visit www.snohomishcountywa.gov/benefits to access all benefits information including summaries, comparison charts, and premiums.
- If you are using this form to modify your current benefit elections, review the list of qualifying Change in Status events (i.e. marriage/divorce/new baby/loss of other healthcare coverage, etc.) on the benefits website that will allow you to modify your benefits.
- In Section 3, if you are changing medical or dental insurance plans, you must include all dependents you would like to cover and all of their personal information. If you need additional space for more dependents, attach a separate sheet.

Step 2: Provide required documents that demonstrate eligibility for dependents and/or documents that support changes.

- For initial enrollments and for all changes in which you are enrolling/removing eligible dependents:
 - Regular employees & retirees: may enroll your spouse or domestic partner and biological/adopted/step children up to the age of 26.
 - Temporary & seasonal employees: you may enroll your biological/adopted children up to the age of 26 in medical insurance only.
 - You must provide documentation that demonstrates eligibility (i.e. marriage certificate/birth certificate, etc.)
 - Social Security numbers (SSNs) are generally required for dependents enrolled in medical, dental and/or vision insurance.
- If changing benefits due to a qualified Change in Status or loss of coverage, you must provide documentation that supports your changes.
- Late applications without supporting documentation may delay or prevent your dependents from enrollment in benefits.

Step 3: HR must receive your application within 30 days from your date of hire/Change in Status or during Open Enrollment.

- Ensure that HR receives this form and required documents by one of the following methods within 30 days from your date of hire, loss of other coverage, or Change in Status. (60 days after the birth of a new baby or adoption); or during the open enrollment period.
- Fax: 425-388-3579 (If you fax, it is recommended that you call HR to verify receipt and keep the fax transmission report.)
 - Mail: Snohomish County Human Resources 3000 Rockefeller Avenue Mailstop 503 Everett, WA 98201

Step 4: Review other benefits - separate enrollment/change forms are required. (Regular Employees Only)

- Life Insurance and Long Term Disability (LTD) Insurance - [Enrollment/Change Form](#)
- Deferred Compensation - [Enrollment Form](#) / [Change Form](#)
- Retirement - Review the [Enrollment Checklist](#) for applicable forms to complete (Forms also available at [New Employee Orientation](#))
- Healthcare & Day Care Flexible Spending Accounts - [FSA Enrollment Form](#) / [FSA Change Form](#)
- Aflac Individual Policies (e.g. Short Term Disability) [Learn more and enroll here](#)

Step 5: Designate and/or review your beneficiaries. (Regular Employees Only)

- Life Insurance - submit the [Life Insurance Beneficiary Designation Form](#) to HR
- Retirement - log in to www.drs.wa.gov or use the [DRS Beneficiary Designation Form](#)
- Deferred Compensation - log in to your [Nationwide account](#) or submit the [Nationwide Beneficiary Update Form](#) to HR

Step 6: Verify your coverage.

- After your effective date, review your [Employee Self Service](#) profile (Intranet Link) and review your profile, dependents, and elections.
- Immediately report any benefits or personal information discrepancies to HR.
- Be sure to check your pay stubs regularly to ensure that premiums are being paid as you have intended.

Additional Information

- Effective dates: New/newly eligible employees - If you were hired between the 1st and the 15th of the month, benefits start the 1st of the next month following your date of hire. If you were hired between the 16th and the 31st of the month, benefits start the 1st of the second calendar month following your date of hire. Current employees who notify HR within 30 days (60 days for the birth of a new baby) whom are eligible to modify their coverage, benefit changes are effective the 1st of the next month following the event; except for the birth of a child which coverage begins on the baby's birthdate; adoption which coverage begins on the date of placement or date of adoption; or loss of coverage which the new coverage will begin on the day after the prior coverage ended. If you are removing coverage, benefits end the last day of the month in which the qualifying Change in Status event occurred.
- Healthcare premiums: Full-time employees (working 35+ hours per week) will share the cost of monthly premiums for Medical Insurance with the County; the County pays the full monthly premiums for Dental, Vision, Basic Life, and Long Term Disability (LTD) Insurance. Part-time employees (working 20 – 34 hours per week) will pay pro-rated monthly premiums for Medical, Dental, Vision, and Basic Life Insurance based on your budgeted FTE; the County pays the full monthly premiums for LTD. Review the [healthcare premiums](#).
- Disclaimer: If there is any discrepancy between information on this form and the official plan documents, the official documents will always govern. Refer to the official documents available at www.snohomishcountywa.gov/benefits for terms, conditions, and exclusions.

Contact Human Resources for assistance: 425-388-3411 ext. 0 | human.resources@snoco.org



Healthcare Benefits Enrollment/Change Form

Snohomish County Human Resources

HR USE ONLY	
Effective Date	
Documentation	<input type="checkbox"/> Marriage Cert <input type="checkbox"/> Birth Cert

① Employee Information					
Last Name	First Name	M.I.	Gender	Date of Birth	
Social Security #	Employee ID #	Hours Per Week	Marital Status	Date of Hire	
Home Mailing Address <input type="checkbox"/> New Address		City	State	Zip	
Employment Type		Department	Home Phone		
<input type="checkbox"/> Regular	<input type="checkbox"/> Temporary & Seasonal (medical only)				

② Reason For Enrollment/Change	
<input type="checkbox"/> New Hire/Newly Eligible	<input type="checkbox"/> Open Enrollment <input type="checkbox"/> Change of Status; Date: _____ Qualifying Event: _____

③ Family Information								
List all dependents if changing medical or dental plans. Attach documentation (i.e. marriage certificate/birth certificate, etc.) to this form.								
EMPLOYEE - SAME AS ABOVE						Medical <input type="checkbox"/> Enroll <input type="checkbox"/> Remove <input type="checkbox"/> Waive <input type="checkbox"/> No change	Dental <input type="checkbox"/> Enroll <input type="checkbox"/> Remove <input type="checkbox"/> Waive <input type="checkbox"/> No change	Vision <input type="checkbox"/> Enroll <input type="checkbox"/> Remove <input type="checkbox"/> Waive <input type="checkbox"/> No change
1	Last Name	First Name	M.I.	Relationship	Medical <input type="checkbox"/> Enroll <input type="checkbox"/> Remove <input type="checkbox"/> Waive <input type="checkbox"/> No change	Dental <input type="checkbox"/> Enroll <input type="checkbox"/> Remove <input type="checkbox"/> Waive <input type="checkbox"/> No change	Vision <input type="checkbox"/> Enroll <input type="checkbox"/> Remove <input type="checkbox"/> Waive <input type="checkbox"/> No change	
	Social Security #	Date of Birth		Gender				
2	Last Name	First Name	M.I.	Relationship	Medical <input type="checkbox"/> Enroll <input type="checkbox"/> Remove <input type="checkbox"/> Waive <input type="checkbox"/> No change	Dental <input type="checkbox"/> Enroll <input type="checkbox"/> Remove <input type="checkbox"/> Waive <input type="checkbox"/> No change	Vision <input type="checkbox"/> Enroll <input type="checkbox"/> Remove <input type="checkbox"/> Waive <input type="checkbox"/> No change	
	Social Security #	Date of Birth		Gender				
3	Last Name	First Name	M.I.	Relationship	Medical <input type="checkbox"/> Enroll <input type="checkbox"/> Remove <input type="checkbox"/> Waive <input type="checkbox"/> No change	Dental <input type="checkbox"/> Enroll <input type="checkbox"/> Remove <input type="checkbox"/> Waive <input type="checkbox"/> No change	Vision <input type="checkbox"/> Enroll <input type="checkbox"/> Remove <input type="checkbox"/> Waive <input type="checkbox"/> No change	
	Social Security #	Date of Birth		Gender				
4	Last Name	First Name	M.I.	Relationship	Medical <input type="checkbox"/> Enroll <input type="checkbox"/> Remove <input type="checkbox"/> Waive <input type="checkbox"/> No change	Dental <input type="checkbox"/> Enroll <input type="checkbox"/> Remove <input type="checkbox"/> Waive <input type="checkbox"/> No change	Vision <input type="checkbox"/> Enroll <input type="checkbox"/> Remove <input type="checkbox"/> Waive <input type="checkbox"/> No change	
	Social Security #	Date of Birth		Gender				

④ If waiving coverage in Section 3:	
By waiving coverage, you acknowledge that you have been offered the opportunity to enroll yourself and your eligible dependents in Snohomish County's group health plans.	
Please choose a reason for waiving coverage below:	
<input type="checkbox"/> My dependents and/or I have other healthcare coverage.	
<input type="checkbox"/> Other Reason: _____	

⑤ Medical Insurance	
<input type="checkbox"/> New enrollment <input type="checkbox"/> No change to current election <input type="checkbox"/> Changing plan election <input type="checkbox"/> Canceling/waiving plan	
Plan	Eligible Employee Group
<input type="checkbox"/> Regence Plan A PPO; #10008695 <input type="checkbox"/> Regence Plan B PPO; #10008695 <input type="checkbox"/> Kaiser Permanente Core HMO; #1654800 <input type="checkbox"/> (JTDs ONLY) - Kaiser Permanente Core HMO; #1654900	Categories: A, B, C, E, H & I Non-represented employees (no union representation), Management & Exempt, AFSCME, Law Enforcement Support, Corrections Support, Corrections Sergeants/Lieutenants, Clerk's Association, Corrections Support Supervisors, & Junior Taxing District (JTD) employees
<input type="checkbox"/> Regence Select \$20 PPO; #10008695 <input type="checkbox"/> Regence Traditional; #10008695 (no new enrollments) <input type="checkbox"/> Kaiser Permanente Core HMO; #1655000	Categories: D & G Sheriff Deputies, Sergeants, Lieutenants, & Captains; Airport Fire Fighters
<input type="checkbox"/> Regence Select \$17 PPO; #10008695 <input type="checkbox"/> Kaiser Permanente Core HMO; #1654700	Category: F Corrections Guild
<input type="checkbox"/> Regence Retiree \$250 PPO Plan A; #10008695	Regular Retirees
<input type="checkbox"/> Regence Retiree \$250 PPO Plan B; #10008695	LEOFF1 Retirees

⑥ Dental Insurance		
<input type="checkbox"/> New enrollment <input type="checkbox"/> No change to current election <input type="checkbox"/> Changing plan election <input type="checkbox"/> Canceling/waiving plan		
Plan	¹ Select dentist if you elected the DeltaCare plan	Additional Information
<input type="checkbox"/> Delta Dental of WA PPO; #00444 <input type="checkbox"/> Delta Dental of WA DeltaCare ¹ ; #00114 <input type="checkbox"/> Willamette Dental Group; #WA175	Select a dentist at www.DeltaDentalWA.com Choice #1: _____ Choice #2: _____	Provided at no cost to regular employees working 35+ hours per week. Regular part-time employees working 20 - 34 hours per week must pay pro-rated <u>monthly premiums</u> .

⑦ Vision Insurance	
Election	Additional Information
<input type="checkbox"/> Enroll <input type="checkbox"/> No change <input type="checkbox"/> Canceling/waiving plan	Coverage is provided at no cost to regular employees working 35+ hours per week. Regular part-time employees working 20 - 34 hours per week must pay pro-rated <u>monthly premiums</u> .

Employee Name	Last Name	First Name
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⑨ Authorization & Signature		
I have read the information and acknowledge that the sections above represent my enrollment choices. I understand that 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. I hereby authorize Snohomish County to deduct the necessary premiums, if any, from my paycheck. I understand that I am solely responsible for the premium payments for my enrollment choices, whether paid through payroll deduction or self-paid while on an unpaid leave of absence. I understand that if I am declining enrollment in healthcare plans for myself and/or my dependents because of other healthcare insurance, I may be able to enroll in healthcare plans through Snohomish County if I am no longer eligible for the other coverage and I request enrollment within 30 days after the other coverage ends.		
Last Name		First Name
Signature		Date

Regence BlueShield | 1800 Ninth Avenue Seattle, WA 98101
 Kaiser Foundation Health Plan of Washington | 601 Union St., Suite 3100, Seattle, WA 98101
 Delta Dental of Washington | 400 Fairview Avenue North, Suite 800 Seattle, WA 98109-05371
 Willamette Dental of Washington, Inc. | 6950 NE Campus Way Hillsboro, Oregon 97124
 Hartford Life and Accident Insurance Company | P.O. Box 2999 Hartford, CT 06104-2999
 Reliance Standard Life Insurance Company | 2001 Market Street, Suite 1500 Philadelphia, PA 19103
 National Union Fire Insurance Company of Pittsburgh, PA (AIG) | 175 Water Street | New York, NY 10038

HR USE ONLY

HRIS Processing

Date:	<input type="checkbox"/> IBEL	<input type="checkbox"/> IBEN	<input type="checkbox"/> IECT	<input type="checkbox"/> IBRA	<input type="checkbox"/> IPSN	<input type="checkbox"/> IEPI
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Notifications

Date:	<input type="checkbox"/> RBS	<input type="checkbox"/> KP	<input type="checkbox"/> DD	<input type="checkbox"/> WDG	<input type="checkbox"/> VSP	<input type="checkbox"/> COBRA
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Plan Changes

Medical	<input type="checkbox"/> New	<input type="checkbox"/> KP > RBS	<input type="checkbox"/> RBS > KP	<input type="checkbox"/> RBS > RBS	Dental	<input type="checkbox"/> New	<input type="checkbox"/> DD > WDG	<input type="checkbox"/> DD > DD	<input type="checkbox"/> WDG > DD
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