2026-2027 Benefit Enrollment Form

A | EMPLOYER SECTION

Date Hired: _____ Coverage Effective Date: _____ ☐ Rehire Date: _____ ☐ Original Full-Time Date of Hire: _____

☐ **New Enrollee** ☐ **Open Enrollment** ☐ **Name Change** ☐ **Address Change** ☐ **Beneficiary Change**
☐ **Special Open Enrollment Event** ☐ **Marriage / Divorce** ☐ **Birth / Adoption** ☐ **Loss of other coverage**

B | EMPLOYEE SECTION – NOTE: IF USING A PO BOX, YOU WILL NEED TO PROVIDE YOUR PHYSICAL ADDRESS AS WELL!

Participant Last Name _____ **First Name** _____ **M.I.** _____

Soc. Sec. # _____ **Date of Birth** _____ **Sex**: ☐ M ☐ F **Telephone Number** _____

Mailing Address _____ **City** _____ **State** _____ **Zip Code** _____

C | BENEFIT ELECTION INFORMATION – PLEASE MAKE A SELECTION IN EACH BOX

Regence Base Plan + Vision Base Copay Plan – Classic 3000 24 Pay Period Cost	Regence HSA Plan + Vision HSA Plan – HSA 3500 24 Pay Period Cost	Regence Buy Up Plan + Vision Buy Up Plan – Classic 1500 24 Pay Period Cost	Voluntary Reliance Standard Dental Plan 24 Pay Period Cost	HSA Contribution
☐ Employee Only ($71.15)	☐ Employee Only ($71.15)	☐ Employee Only ($108.05)	☐ Employee Only ($23.03)	If enrolled in the **HSA plan**, you may also contribute money out of your own paycheck on a pre-tax basis.
☐ Employee & Spouse ($417.25)	☐ Employee & Spouse ($396.83)	☐ Employee & Spouse ($499.00)	☐ Employee & Spouse ($46.06)	For **2026**, the maximum individual contribution is $**4,400** and the maximum family contribution is $**8,750**. A "catch up" contribution of $1,000 is also available to those age 55+.
☐ Employee & Children ($337.10)	☐ Employee & Children ($320.58)	☐ Employee & Children ($408.45)	☐ Employee & Children ($54.49)	
☐ Employee & Family ($683.20)	☐ Employee & Family ($649.83)	☐ Employee & Family ($799.45)	☐ Employee & Family ($77.52)	**Pay Period Contribution:**_____
☐ **Waive Medical (and complete Section D on page 2)**			☐ **Waive Dental**	

Coverage Elected	First Name	Last Name	Social Security Number *(Required)*	Sex	Relationship (i.e. spouse, child)	Date of Birth
☐Medical & Vision ☐Dental						
☐Medical & Vision ☐Dental						
☐Medical & Vision ☐Dental						
☐Medical & Vision ☐Dental						
☐Medical & Vision ☐Dental						

Note: *Enrollment in the plan will not be processed if this enrollment form is submitted incomplete, including the applicant's signature and date signed. Notify the plan immediately of a change in address, or within 31 days of a change in status, over age dependent addition, or special enrollment opportunity, or within 60 days of a birth, adoption or placement for adoption*

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D | WAIVING OF MEDICAL INSURANCE

If you have medical coverage through another source and are waiving out of our medical benefits, please complete the following information:

Provide the following information on the carriers listed above:

Subscriber's Name: _____ Subscriber's Relationship: _____ Subscriber's Employer's Name: _____

Carrier Name: _____ Policy Number: _____ ☐ Individual Policy ☐ Group/Employer Policy

Is Employee, Spouse/Domestic Partner covered under this medical plan eligible for Medicare benefits? ☐ Yes ☐ No

If yes, enter date of eligibility for Medicare Part A _____ Medicare Part B _____

Please note – if you are waiving **Pacific Facility Solution's** coverage because you are receiving a premium subsidy on an individual policy through the Washington Health Plan Finder, be aware that **Pacific Facility Solution** meets the criteria for offering an affordable plan that means minimum essential coverage and minimum value under the ACA. This means that if you waive **Pacific Facility Solution's** coverage and keep the individual policy, you may become ineligible for the premium subsidy.

F | SIGNATURE SECTION

I certify that the above listed information is correct and that I am enrolling only eligible dependents as defined in the Plan Document. I understand that all entitlements to benefits are void, and coverage may be canceled or modified retroactively to its effective date, if I have made intentionally false or misleading statements or answers on behalf of myself or any family members. I authorize any person or institution providing care or services, or any organization in possession of insurance benefit information to release any and all information pertaining to the care or benefits provided to me or my dependents to **Regence BlueShield, Reliance Standard, Ameritas, VSP** and their designated agent(s). I acknowledge and understand that my health plan may request or disclose health information about me or my dependents (persons who are listed for benefits coverage on the enrollment form) from time to time for the purpose of facilitating health care treatment, payment or for the purpose of business operations necessary to administer health care benefits; or as required by law. For more information about such uses and disclosures, including uses and disclosures required by law, please refer to the Privacy Notice. A copy is available from the Human Resources Department upon request.

Health information requested or disclosed may be related to treatment or services performed by: 1) A physician, dentist, pharmacist or other physical or behavioral health care practitioner; 2) A clinic, hospital, long term care or other medical facility; 3) Any other institution providing care, treatment, consultation, pharmaceuticals or supplies; or 4) An insurance carrier or group health plan. Health information requested or disclosed may include, but is not limited to: claims records, correspondence, medical records, billing statements, diagnostic imaging reports, laboratory reports, dental records, or hospital records (including nursing records and progress notes). This acknowledgement does not apply to obtaining information regarding psychotherapy notes. A separate authorization will be used for psychotherapy notes.

Changes can only be made during the annual open enrollment period, unless there is a qualifying event, such as the person becomes covered under another plan, or loss of employment.

Salary Deduction Agreement: I understand I have the right to have the company redirect my salary on a PRETAX basis during the plan year & apply this premium amount toward the purchase of the medical/vision/dental coverage I have designated. I understand that my share of the cost of this coverage may be adjusted to reflect the change in rates. I authorize the company to adjust my pay as required by my elections on this form.

I consent to the electronic disclosure of all Employee Benefit notices, including Summary Plan Descriptions and plan amendments. I acknowledge that I have read the contents of this notice and understand that I am entitled to withdraw my consent at any time at no cost to myself. I understand that I have the right to receive paper copies of all Employee Benefit notices, including Summary Plan Descriptions and plan amendments, upon request at no additional charge. I also confirm that I have the ability and the necessary equipment and software to access the Employee Benefits websites, view the documents and print copies.

Employee's Signature: _____ Date Signed: _____

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