Employee Enrollment and Change Form 2026

OLYMPIC BENEFITS TRUST

Please send completed form to billing@tbsmga.com

KAISER PERMANENTE® Ameritas VSP VISION DELTA DENTAL Delta Dental of Washington

EMPLOYER: PLEASE COMPLETE THIS SECTION.

Coverage Effective Date ____/____/____
Group Name _____
Group Number _____

Hours Worked Per Week _____
Original Date of Hire ____/____/____
Date of Re-Hire ____/____/____
Date transferred from part time to full time ____/____/____

Qualifying Event Description (choose one)
☐ Open Enrollment ☐ New Employee
☐ Add Dependent ☐ Address/name change
☐ Remove Coverage ____Subscriber ____Dependent
Date of Qualifying Event: ____/____/____
Prior Medical Carrier: _____
Coverage end date ____/____/____

☐ Transfer to COBRA
Start Date ____/____/____
☐ 18 Months
☐ 36 Months

EMPLOYEE: COMPLETE THE FOLLOWING. *(PLEASE PRINT, *indicates required field)*

*Last	First	MI	*Date of Birth / /	*Gender ☐ M ☐ F	*Social Security #
*Mailing Address: City, State, Zip			*Home Phone		Work Phone
*Marital Status: ☐ Single ☐ Married Date Married: ____/____/____ ☐ State Registered Domestic Partnership Washington State Registered Domestic Partners are treated the same as a spouse			E-mail address*		

*Add or Remove (circle one)	*Name of Dependent (If dependent has different mailing address, please attach) Last First MI	*Social Security Number	*Gender (Circle One)	*Birth Date (children age 26 or over requires certificate)	Relationship to Employee
Add/Delete	Spouse/Registered Domestic Partner		M F	/ /	
Add/Delete	Child		M F	/ /	
Add/Delete	Child		M F	/ /	
Add/Delete	Child		M F	/ /	
Add/Delete	Child		M F	/ /	

*Dependent children are eligible for coverage through the age of 25 regardless of marital status, student status, or eligiblity for coverage under another plan

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PLAN SELECTIONS	
Medical and Prescription Drug (Rx) Plan Selection Kaiser Foundation Health Plan of Washington or Kaiser Foundation Health Plan of Washington Options, Inc	☐ Employee only (EE) ☐ EE & Spouse ☐ EE & + Children ☐ EE & Family Please see your employer for plan details. If more than one health plan is offered, please write in your choice, including the group number below: *Health Plan* _____ *Group number*_____
Dental Plan Selection Ameritas Dental or Delta Dental of Washington	☐ Employee only (EE) ☐ EE & Spouse ☐ EE & + Children ☐ EE & Family Dental Plan Choice: _____
Vision Plan Selection Ameritas Vision or VSP Direct	☐ Employee only (EE) ☐ EE & Spouse ☐ EE & + Children ☐ EE & Family Vision Plan Choice: _____

Employee Signature: The undersigned understands that it is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purposes of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits. The changes on this form supersede all previous forms submitted. I authorize my employer to deduct from my earnings the amount, if any, for the coverage selected.

Employee Signature	Date Signed

Endorsed Carrier Contact Information

Total Benefit Solutions: 155 108th Ave NE, Ste. 800, Bellevue, WA 98004; Customer Service 800.514.4850

Kaiser Permanente: 2715 Naches Ave. SW Renton, WA 98057; Customer Service 888.901.4636

Ameritas: 5900 O Street, Lincoln, NE 68501; Customer Service 800.659.2223

Delta Dental of Washington: 400 Fairview Ave N, Seattle, Washington 98109-5371

VSP Direct: 3333 Quality Drive, Rancho Cordova, CA 95670