155 108th Ave NE Suite 800 Bellevue, WA 98004
Phone: 800-514-4850
Email: billing@tbsmga.com

Member Application / Change Request Form for Group Coverage Sponsored by the Olympic Benefits Trust Delta Dental of WA and VSP Only

Dental offered and underwritten by the following carriers: DELTA DENTAL of Washington, 400 Fairview Avenue N, Ste 800, Seattle WA 98109-5371	**Vision offered and underwritten by:** Vision Service Plan, 3333 Quality Drive, Rancho Cordova CA 95670

EMPLOYER MUST COMPLETE THIS SECTION AND CHECK APPROPRIATE BOXES:

EMPLOYER NAME:		**Add Employee Coverage**	**Change in Enrollment**		**Intended Effective Date:**
Telephone #:	**Department/Division:**	☐ New Group ☐ New Employee ☐ Open Enrollment	☐ Name ☐ Address ☐ Dependent	☐ Loss of Coverage ☐ Change in Coverage ☐ Transfer to COBRA	/ /
Original Hire Date:	**Part-Full Time Date:** **Re-Hire Date:**	**Weekly Hours Worked:**	**Employee Class:** ______________		☐ Hourly ☐ Salary

EMPLOYEE MUST COMPLETE THE FOLLOWING (Even if coverage is being waived)

Employee Last Name:	First Name:		M.I.	*Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Registered Domestic Partner		Date of Marriage:
Employee Address:	City:	State:	Zip:	Home Phone:		Work Phone:

Enrollment Election: Please check all applicable boxes for each enrolling member of the family

Delta Dental	VSP Vision	ADD	TERM	Last Name First Name MI	Social Security #	Sex	Birth Date MM/DD/YY	Relationship
☐	☐	☐	☐			☐ M ☐ F		**Self**
☐	☐	☐	☐			☐ M ☐ F		☐ Spouse or ☐ State Reg. DP
☐	☐	☐	☐			☐ M ☐ F		☐ Child ☐ Other
☐	☐	☐	☐			☐ M ☐ F		☐ Child ☐ Other
☐	☐	☐	☐			☐ M ☐ F		☐ Child ☐ Other

WAIVER SECTION

You can waive if you have other coverage, please complete the name and address information above and check each box for the coverage being waived: ☐ ***Dental*** ☐ ***Vision***

I have been offered benefits by my employer and I hereby decline enrollment in my employer's dental and/or vision coverage. ***(NOTE: you must provide proof of other coverage)***

**References to Marriage, Divorce, or Spouse apply equally to a same-sex, or an opposite-sex spouse, and to a registered domestic partner.*

I apply for enrollment with each carrier for myself and my dependents listed and certify that (a) to the best of my knowledge, we are eligible for the coverage requested; (b) I have reviewed the product information and understand the exclusions, limitations, and waiting periods stated therein; and (c) all information on this form is true, correct, and complete. The changes on this form supersede all previous forms I have submitted. **I authorize my employer to deduct from my pay the amount, if any, to pay for the premiums for the coverage's I have elected.** 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's Signature______________________________ **Date Signed**____________________