IAFF LOCAL 726
Administered by Vimly Benefit Solutions, Inc.
P.O. Box 6, Mukilteo, WA 98275
***P:** (425)-367-0732 | **F:** (866) 676-1530 | **E:** Local726@vimly.com*

LOCAL 726 HEALTH & WELFARE TRUST
2026 ACTIVE ENROLLMENT FORM

Please Print Clearly

Reason for Submission:
☐ Open Enrollment ☐ New Employee ☐ Address Change ☐ Name Change ☐ Loss of Other Coverage*
☐ Family Member Update: _____ ☐ Other: _____

**Enrollments due to losing other coverage will require proof of coverage termination.*

Date of Hire:	**Coverage Effective Date:**

**Coverage will go into effect the 1st of the month following date of hire or immediately following loss of coverage.*

Please Indicate Employment Status:
☐ South Pierce Fire ☐ Central Pierce Fire ☐ Non-Uniform ☐ Non-Represented Chiefs ☐ Chiefs

PERSONAL INFORMATION

First Name:	Middle Name:	Last Name:	
Street Address:			SSN:
City:	State:	Zip:	Date of Birth:
Marital Status:	Date of Marriage/Divorce:		Gender: ☐ M ☐ F
Home Phone:	Cell Phone:	Preferred Email:	

MEDICAL PLAN – MagnaCare

Plan $100

DENTAL PLANS *(Choose One)* – Washington Counties Insurance Fund

☐ **Delta Dental Plan** ☐ **Willamette Dental Plan**

You are committed to your plan selections for the 2026 Plan Year.
You will have the opportunity to make a change during the next open enrollment period for the 2027 Plan Year OR if you have a Qualifying Change of Status (marriage, birth, divorce, etc.).

FAMILY MEMBER ENROLLMENT: List below any family members you wish to cover. If you are changing the status of your family members, please mark the ADD or DELETE boxes accordingly. **Coverage for dependents will be effective the 1st of the month following qualifying life event, except newborns, for which coverage will go into effect as of their date of birth.** ***Family member DOB and SSN are required!***

Name of Family Member	Date of Birth	Relationship to Member	Gender	SSN	Action
			☐ M ☐ F		☐ Add ☐ Delete
			☐ M ☐ F		☐ Add ☐ Delete
			☐ M ☐ F		☐ Add ☐ Delete
			☐ M ☐ F		☐ Add ☐ Delete

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FAMILY MEMBER ENROLLMENT *(continued)*:

Name of Family Member	Date of Birth	Relationship to Member	Gender	SSN	Action
			☐ M ☐ F		☐ Add ☐ Delete
			☐ M ☐ F		☐ Add ☐ Delete
			☐ M ☐ F		☐ Add ☐ Delete

THIS ENROLLMENT FORM IS NOT VALID UNLESS IT IS SIGNED AND DATED

Enrollment information that I previously submitted for a specific insurance plan is superseded by changes indicated on this form. By signing below, I acknowledge that I wish to enroll myself and my family members in the medical/dental plan coverage as indicated on the front of this form and that my employer may deduct applicable premiums from my payroll. I certify that the family members enrolled on this form meet the definition of Eligible Family Member, as defined in Plan Certificate of Coverage and incorporated into the "Enrollment Guide of the Local 726 Health & Welfare Trust".

By signing below, I declare that the information on the Enrollment Application is true, correct, and complete to the best of my knowledge, and that I have read and understand the Enrollment Application and Enrollment Guide covering the options provided under the plan. I authorize the Trust's insurance carriers and administrators to obtain, examine or release information needed to coordinate benefits or process claims for me or my family. I understand that it is a crime to knowingly provide false, incomplete, or misleading information to an insurance company. Penalties include imprisonment, fines and denial of insurance benefits.

_____ _____
Signature Date

_____
Print Name

ENROLLMENT FORMS MUST BE SUBMITTED WITHIN 30 DAYS OF THE EMPLOYEE OR DEPENDENT BECOMING ELIGIBLE, WITH THE EXCEPTION OF NEWBORNS, FOR WHICH ENROLLMENT FORMS MUST BE SUBMITTED WITHIN 60 DAYS OF BIRTH.

Please return form to the Trust Office at:

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