IAFF LOCAL 726
Administered by Vimly Benefit Solutions, Inc.
P.O. Box 6, Mukilteo, WA 98275
***P:** (866) 265-5231 | **F:** (866) 676-1530 | **E:** IAFFHealthTrust@vimly.com*

LOCAL 726 HEALTH & WELFARE TRUST
2026 RETIREE ENROLLMENT FORM (NON-MEDICARE) – SPOUSE/DEPENDENT

Please Print Clearly

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

**Enrollments due to losing other coverage will require proof of coverage termination, with the exception of COBRA coverage offered through NWFFT.*

Status: ☐ Surviving Spouse/Dependent ☐ Spouse/Dep of Medicare-Eligible Retiree ☐ Spouse/Dep of LEOFF 1 Retiree
☐ Spouse/Dep of Non-Medicare-Eligible Retiree **Name of Retired Fire Fighter:** _____

Date of Retirement:	**Coverage Effective Date:**

Employer Group Retired From: ☐ Central Pierce F&R
☐ Graham F&R ☐ South Pierce F&R ☐ CPFR Mechanics ☐ CPFR Chiefs ☐ CPFR Deputy Chiefs ☐ CPFR IT

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:	

RETIREE MEDICAL PLANS – MagnaCare
**If higher-deductible option is selected, retiree is not permitted to change to lower-deductible option at renewal.*

☐ **Plan $100** ☐ **Plan $1500** ☐ **Plan $5000**

DENTAL PLANS *(Choose One)* – Washington Counties Insurance Fund
**One-time election for new retirees only; participating actives must be enrolled in WCIF Dental.*

☐ **Delta Dental Retiree 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 Social Security Numbers are required!***

Name of Family Member	Birthdate	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

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COORDINATION OF BENEFITS: If you or any family members currently have other group medical or dental coverage (including Medicare), please complete below:

Medical	Dental	Name of Family member	Name of Insurance and /or Policyholder Name	Date coverage began	Date coverage ended	Medicare List A, B or Both	Plan Number or Medicare HIC #
☐	☐						
☐	☐						
☐	☐						

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 "Summary Plan Description of the IAFF Health & Wellness 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

Please select your payment option below.

☐ DRS $_____ ☐ DRS Authorization Form Attached ☐ On File

I authorize the Department of Retirement Systems (DRS) to regularly deduct a sufficient amount from my retirement benefit to pay the premiums for my insurance coverage. I will not hold DRS responsible for any problems on coverage or premium charges that occur between the insurance carrier and myself. The deductions will continue until I write to the insurance company and DRS asking for my deductions to stop or I terminate the insurance plan. I understand that DRS cannot answer questions about my insurance.

☐ DEBIT $_____ ☐ ACH Authorization Form Attached ☐ On File

☐ Bill Retiree Premium to Employer (LEOFF 1's only) & Bill Dependent Premiums to Retiree*

ENROLLMENT FORMS MUST BE SUBMITTED WITHIN 30 DAYS OF THE RETIREE ORDEPENDENT BECOMING ELIGIBLE.

Please return form to the Trust Office at:
Vimly Benefit Solutions
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Ph: (866) 265-5231 **Fax:** (866) 676-1530 **Email:** IAFFHealthTrust@vimly.com