DEPENDENT CHILDREN OF DIVORCED OR SEPARATED PARENTS

If any dependent(s) added to coverage is covered under another health care plan and the natural parents are divorced or separated, Washington State regulations require that the information requested below be completed in full.

Name of Parent with Custody (if parents have dual custody, indicate) _____ Birth Date of Other Parent _____

If divorced, did a court establish financial responsibility for the child(ren)'s health care? ❑No ❑Yes, the responsible person(s) are:

Name _____ Street Address or PO Box _____

City _____ State _____ Zip Code _____ Phone Number _____

OTHER INSURANCE DATA

THIS FORM WILL BE RETURNED IF THIS SECTION IS NOT **COMPLETED IN FULL**, WHICH WILL DELAY THE ENROLLMENT PROCESS.

❑ Check here if you or your dependents have no other vision insurance.

If you or any of your dependents have coverage with any other health care plan (coverage through an insurance company, a self-insured plan, a group retiree medical plan, including MEDICARE) or Northwest Benefit Network, please complete this section.

	Policy No. 1	Policy No. 2	Policy No. 3
Type of Healthcare Coverage	Vision	Vision	Vision
Name of Insured Person			
SSN of Insured Person			
Name(s) of Dependent(s) covered under this insurance			
Insured's Relationship to Dependent(s)			
Name of Insured Person's Employer			
Name of Insurance Company			
Insurance Co. Street Address or PO Box			
City State, Zip Code			
Insurance Company Phone No.			
Group or Policy Number			
Effective Date of Coverage			

FAILURE TO FILE OR UPDATE YOUR PARTICIPANT DATA WITH THE ADMINISTRATIVE OFFICE MAY DELAY THE PROCESSING OF YOUR CLAIMS

It is a crime to knowingly provide false, incomplete, or misleading information to the Vision Plan Administrative Office for the purpose of defrauding the Vision Plan. Penalties include imprisonment, repayment of all claims paid inappropriately, fines, and denial of insurance benefits.

With my signature, I hereby certify that the information provided on this Participant Data Form is true and correct and 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 the Northwest Benefit Network or its designated agent.

× _____ _____

PARTICIPANT'S SIGNATURE DATE SIGNED

NORTHWEST BENEFIT NETWORK VISION PLAN

Participant Data Form

INSTRUCTIONS: Complete EACH section front and back. SIGN and DATE. Use INK. PRINT. Data provided will replace all information on file with Northwest Benefit Network. For questions, call 1 (800) 732-1123.

ADMINISTRATIVE USE ONLY
Date: ____________
Initials: ____________

MAIL TO: Northwest Benefit Network
2323 Eastlake Avenue East
Seattle WA 98102-3393

Fax: (206) 926-2699
Email: NBNEnrollment@nwadmin.com

NOTE: You may register at www.nwadmin.com and make future changes to your participant data using the Participant Data Form available on-line.

PARTICIPANT DATA

___ - ___ - ___ Social Security Number

☐ Male ☐ Female

Date of Birth ____________

Participant Last Name ____________ First Name ____________ Middle Initial ____________

Mailing Address ____________

☐ Single
☐ Married – date: ____________
☐ Domestic Partner – date: ____________
(If your employer provides domestic partner coverage)
☐ Divorced – date: ____________

City ____________ State ____________ Zip Code ____________

Employer (Company Name) ____________ Date of Hire ____________ Home Phone Number ____________

ELIGIBLE DEPENDENT DATA

☐ Check here if you have no spouse or eligible dependents as described below. If you do have eligible dependents, complete this section and list ALL your eligible dependents each time you submit this form. Eligible dependents include the following (see plan book for complete details):

1. Your spouse.
2. Your natural or adopted children and step-children, and children of your domestic partner *if your employer provides domestic partner coverage* under 26 years of age ***or*** incapable of self-support because of mental or physical incapacities.
3. Your domestic partner *if your employer provides domestic partner coverage*. Domestic partnership enrollment subject to verification.
4. Your unmarried grandchildren, children for whom you have been appointed guardian by the court, under 26 years of age or incapable of self-support because of mental or physical incapacities. ***Please attach proof of dependency or guardianship.***

Proof may be requested if determined necessary; i.e. birth certificate, guardianship papers, proof of incapacity, marriage certificate, divorce papers, etc.

Please read #2 and #4 above before listing children. Last Name / First / Initial	Date of Birth	Relation	Social Security No.	Gender	Does child live with you?
			- -	M☐ F☐	Yes ☐ No ☐
			- -	M☐ F☐	Yes ☐ No ☐
			- -	M☐ F☐	Yes ☐ No ☐
			- -	M☐ F☐	Yes ☐ No ☐
			- -	M☐ F☐	Yes ☐ No ☐
			- -	M☐ F☐	Yes ☐ No ☐
			- -	M☐ F☐	Yes ☐ No ☐
			- -	M☐ F☐	Yes ☐ No ☐
			- -	M☐ F☐	Yes ☐ No ☐
			- -	M☐ F☐	Yes ☐ No ☐

PLEASE COMPLETE REVERSE SIDE. PARTICIPANT MUST SIGN AND DATE FORM