Seattle
Department of Human Resources

Vision Buy Up Enrollment Form
Most Temporary Benefits Eligible (TBE) to Regular Employee

Employee Information: (Please print)

Last Name	First Name	Employee # or last 4-digits of SSN	Birth Date (mm/dd/yyyy)

Coverage Options:

Vision Insurance	Employee Premium Share (with or without spouse/domestic partner/children)
VSP - Buy Up	$10.38
VSP – Basic	$0.00

Add Dependent Coverage Information:

List all eligible dependents to be included. Attach list for any additional dependents. If you enroll a dependent, the City's business partner, Alight Solutions, will send a letter to your home requesting documents that confirm the eligibility of your dependent. For more information visit https://bit.ly/Citydev

Spouse / Domestic Partner — Reset this section

Relationship	◯ Spouse	◯ Domestic Partner (**Yes - IRS Tax Dependent**)	◯ Domestic Partner (**No - Not IRS Tax Dependent**)

Last Name	First Name	MI	SSN	DOB (mm/dd/yyyy)	Gender
			- -		◯ Male ◯ Female ◯ X *

Dependent Child #1

Relationship	◯ Employee's Child ◯ Son ◯ Daughter	◯ Stepchild ◯ Son ◯ Daughter	◯ Domestic Partner's Child ◯ Son ◯ Daughter	◯ Legal Guardian ◯ Son ◯ Daughter
	Is the child incapacitated or Disabled? ◯ Yes ◯ No (If yes and your child is age 26 or older, contact Benefit Rep to begin verification process)			

Last Name	First Name	MI	SSN	DOB (mm/dd/yyyy)	Gender
			- -		◯ Male ◯ Female ◯ X*

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Dependent Child #2					
Relationship	◯ Employee's Child ◯ Son ◯ Daughter	◯ Stepchild ◯ Son ◯ Daughter	◯ Domestic Partner's Child ◯ Son ◯ Daughter	◯ Legal Guardian ◯ Son ◯ Daughter	
	Is the child incapacitated or Disabled? ◯ Yes ◯ No (If yes and your child is age 26 or older, contact Benefit Rep to begin verification process)				
Last Name	First Name	MI	SSN	DOB (mm/dd/yyyy)	Gender
			- -		◯ Male ◯ Female ◯ X *

Dependent Child #3					
Relationship	◯ Employee's Child ◯ Son ◯ Daughter	◯ Stepchild ◯ Son ◯ Daughter	◯ Domestic Partner's Child ◯ Son ◯ Daughter	◯ Legal Guardian ◯ Son ◯ Daughter	
	Is the child incapacitated or Disabled? ◯ Yes ◯ No (If yes and your child is age 26 or older, contact Benefit Rep to begin verification process)				
Last Name	First Name	MI	SSN	DOB (mm/dd/yyyy)	Gender
			- -		◯ Male ◯ Female ◯ X *

*X means a gender that is not exclusively male or female.

Note: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the insurance company. Penalties may include imprisonment, fines and denial of insurance benefits.

Acknowledgement Signature:

Reset this section

◯ **I Accept VSP - Buy Up Coverage**

Previously submitted enrollment information for a specific insurance plan is superseded by changes indicated on this form. I certify that my family members and I are eligible for the coverage requested. I authorize the City to deduct from my earnings any premium I am required to pay for the coverage I selected above.

By signing below, I declare that the information on this form is true, correct and complete to the best of my knowledge; that I have read and understood the election form and descriptive material covering the options provided under the City of Seattle's benefit plans. I authorize the insurance carriers to obtain, examine or release information needed to coordinate benefits or process claims for myself or my family. I understand I may be subject to disciplinary action and/or repayment of any claims paid by my health plan or premiums paid by my employer if I have provided false, incomplete, or misleading information, or fail to update this information in accordance with eligibility guidelines.

Employee's Signature: Date (mm/dd/yyyy):

◯ **I Waive VSP - Buy Up Coverage**

I understand that by declining the VSP Buy Up plan, my dependents and I will remain on the Basic VSP plan. The next opportunity to enroll in the VSP Buy Up plan will be during Open Enrollment.

Employee's Signature: Date (mm/dd/yyyy):