*Administered by Vimly Benefit Solutions, Inc.*
*PO Box 6 • Mukilteo, WA 98275*
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# Enrollment Application

Check One: ☐ First Enrollment ☐ Dependent Change ☐ Address Change ☐ Name Change

**PERSONAL INFORMATION:** ***Please Print Clearly***

| | | | | |
|---|---|---|---|---|
| Member Name: | | | | - - |
| | *Last* | *First* | *MI* | Social Security Number |
| Address: | | | | |
| City: | | State: | Zip: | Effective Date: |
| Phone: | | Personal Email: | | |
| Gender: ☐M ☐F | Date of Birth: | Marital Status: | Date of Marriage: | |

**FAMILY MEMBER INFORMATION:**

| Full Name | Birthdate | Relationship to Employee | Gender | SSN | |
|---|---|---|---|---|---|
| 1). | | | ☐ M ☐ F | - - | ☐ Add ☐ Delete |
| 2). | | | ☐M ☐F | - - | ☐ Add ☐ Delete |
| 3). | | | ☐M ☐F | - - | ☐ Add ☐ Delete |
| 4). | | | ☐M ☐F | - - | ☐ Add ☐ Delete |
| 5). | | | ☐M ☐F | - - | ☐ Add ☐ Delete |
| 6). | | | ☐M ☐F | - - | ☐ Add ☐ Delete |

***If you have additional dependents, you may list them on the back of this application.**

**Pursuant to the confirmation election of my member association, my employer will contribute an amount as specified in the local's collective bargaining agreement on my behalf to the PORAC Medical Expense Reimbursement Plan.**

**Participant Signature:** _____ **Date:** _____

***Internal Use Only:***

*Employer Name:* *Employer Billing Number:*

*Date Received:* _____ *Date Processed:* _____ *Initials:* _____