Seattle
Department of Human Resources

Add Dependents to Medical, Dental and Vision Insurance Form

Employee Information: (Please print)

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

Qualifying Event: (Please check one)

Reset this section

You have 30 days, from the qualifying event, to notify your department's Benefits Representative that you wish to add a new dependent. You have 60 days from the date of birth/adoption of your child to notify your representative.

Qualifying Event	Date
◯ **New Marriage / Domestic Partnership** (Attach Affidavit of Marriage/Domestic Partnership form)	Date Finalized:
◯ **Birth / Adoption** (Legal adoption or interim adoption document)	Date of Birth or Court Recorded:
◯ **Court Order / Legal Guardianship** (Attach final court document signature page showing proof)	Court Recorded:
◯ **COBRA Coverage Ended from Other Employer** (Attach proof of that coverage end date)	Last Date of Coverage:
◯ **Loss of Medical Coverage from Other Employer** (Attach proof of other coverage)	Last Date of Other Coverage:
◯ **Other** (explain):	

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.

Add Dependent Coverage:

List all eligible dependents to be added to the applicable plans. Attach a list for any additional dependents.

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	Birth Date (mm/dd/yyyy)	Gender
			- -		◯ Male ◯ Female ◯ X*

Enroll In (check boxes as applicable)	☐ Medical	☐ Dental	☐ Vision

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Dependent Child #1 Reset this section

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 your Benefits Rep to begin the verification process)			

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

Enroll In (check boxes as applicable)	☐ Medical	☐ Dental	☐ Vision

Dependent Child #2 Reset this section

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 your Benefits Rep to begin the verification process)			

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

Enroll In (check boxes as applicable)	☐ Medical	☐ Dental	☐ Vision

Dependent Child #3 Reset this section

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 your Benefits Rep to begin the verification process)			

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

Enroll In (check boxes as applicable)	☐ Medical	☐ Dental	☐ Vision

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

Acknowledgement Signature:

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.

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

Benefits Administration Use Only:		
First Day of Coverage:	Date Entered into HRIS:	Payroll Adjustment Requested PPE: (as applicable, start after-tax ded. & imputed income)
Initial COBRA Notice Sent (Spouse/DP Only):	Benefits Rep. Signature & Date:	