

WESTERN BUILDING MATERIAL INSURANCE TRUST

Employee Census Form

Firm Name: _____

Contact: _____

Current Insurance Carrier: _____

Employee (Initials Sufficient)	Birthdate (MM/DD/YY)	Medical Coverage Requested See Code Below	Dental Coverage Requested See Code Below*	PLAN(s) Requested MEDICAL <i>(Vision included)</i>
				\$25 Co-pay <input type="checkbox"/> \$500 Deductible (80/50 coinsurance)
				\$25 Co-pay <input type="checkbox"/> \$1,000 Deductible (80/50 coinsurance)
				\$25 Co-pay <input type="checkbox"/> \$1,500 Deductible (80/50 coinsurance)
				DENTAL (yes or no)

				LIFE AMOUNT
				\$ _____
				Up to \$20,000; \$5,000 required
				WEEKLY DISABILITY
				\$ _____
				(\$150, 250 or 350) (not required)

Coverage Requested

Employee Only
 Employee and Spouse
 Employee, Spouse and Child(ren)
 Employee and Child(ren)

Code

E
 ES
 ESC
 EC

Return this form to:

Western Building Material Association
 P.O. Box 1699
 Olympia, WA 98507-1699
 FAX (360) 943-1219

* You must be covered on medical to be eligible for dental.
 Dependents covered on medical not required to be covered on dental.