# CITY OF TACOMA
# Group Insurance Plan Enrollment/Change Form
# [Retirees Only]

***This form supersedes all other forms. Please PRINT CLEARLY in blue or black ink.***

**SECTION 1:** ***All Retirees Must Complete This Section***

| Social Security Number | Last Name | First Name | M.I. | ☐ Male ☐ Female | Date of Birth mm dd yyyy |
|---|---|---|---|---|---|
| | | | | | |

Mailing Address:

City State Zip

Phone Number

Home (_____) _____ - _____ Cell (_____) _____ - _____

Email _____

**SECTION 2:** ***Please Check Your Selections Below***

**Medical Plan** **Group #10010327**

***TERS Retiree*** *{SG 0003}*

☐ Regence PPO *[MESA 1001](CL 0005)*

☐ Regence HDHP *[MHSA 1001](CL 0005)*

***LEOFF II Retiree*** *{SG 0003}*

Regence PPO Plan

*[MESA 3001] (CL 0006)* ☐

*[MESA 1101] (CL 0007)* ☐

*[MESA 1301] (CL 0008)* ☐

Regence High-Deductible HDHP

*[MHSA 1001] (CL 0006)* ☐

*[MHSA 1001] (CL 0007)* ☐

Group Health Plan (Local 6 only) ☐

**Medical Plan** **Group #10010327**

***LEOFF I Retiree*** *{SG 0003}*

Regence PPO - Under 65

*[MENG 5001] (CL 0009)* ☐

*[MENG 5001] (CL 0011)* ☐

Regence PPO Over 65

*[MENG 4001] (CL 0009)* ☐

*[MENG 4001] (CL 0011)* ☐

*[MENG 6001] (CL 0011)* ☐

***Regence PPO – Retiree Dependents*** *{SG 0004}*

*[MESA 6001] (CL 0013)* ☐ *[MESA 8001](CL 0013)* ☐

***Regence PPO – Retiree Dependents*** *{SG 0004}*

*[MESA 6001] (CL 0014)* ☐ *[MESA 8001] (CL 0014)* ☐

**Dental Plans** ***TERS Retiree (ONLY)***

☐ Delta Dental of WA *(00205)*

☐ Willamette Dental of WA, Inc. *(WA142)*

☐ **New Enrollment** ☐ **Cancel Enrollment**

☐ **Open Enrollment** ☐ **Add Dependent**

☐ **Drop Dependent** ☐ **Address Change**

☐ **Name Change** ☐ **Other** (list below)

_____

**EFFECTIVE DATE** _____

**SECTION 3:** ***DEPENDENT INFORMATION – SPOUSE / DOMESTIC PARTNER (Use additional forms to list additional dependents)***

| ☐ **Spouse** ☐ **Domestic Partner** ☐ Add ☐ Drop ☐ Medical ☐ Dental | Last Name | First Name | MI | Social Security Number | Date of Birth | Gender ☐ M ☐ F<br>Date of Marriage/Partnership: |
|---|---|---|---|---|---|---|
| | | | | | | |

***CHILD / CHILDREN***

| ☐ Add ☐ Drop ☐ Medical ☐ Dental | Last Name | First Name | MI | Social Security Number | Date of Birth | Gender ☐ M ☐ F |
|---|---|---|---|---|---|---|
| | | | | | | |
| ☐ Add ☐ Drop ☐ Medical ☐ Dental | Last Name | First Name | MI | Social Security Number | Date of Birth | Gender ☐ M ☐ F |
| | | | | | | |

**SECTION 4:** ***SIGNATURE OF RETIREE***

| | **Date** |
|---|---|
| | |

**IMPORTANT NOTE: Please be sure to mail this form to the appropriate office, see below.**

| **TERS Retiree** | **LEOFF I Retiree** | **LEOFF II Retiree** | **Retiree Pension Plan** _____ |
|---|---|---|---|
| Retirement Department<br>PO Box 11007, Tacoma, WA 98411-0007<br>Phone: (253) 502-8200 Fax: (253) 502-8660 | Retirement Department<br>PO Box 11001, Tacoma, WA 98411-0001<br>Phone: (253) 502-8700 Fax: (253) 502-8660 | Human Resources Department<br>747 Market St Rm 1420, Tacoma, WA 98402<br>Phone: (253) 573-2345 Fax: (253) 591-5873 | **Date of Retirement** ____/____/_____ |

| Regence BlueShield | Group Health | Delta Dental of Washington | Willamette Dental of Washington |
|---|---|---|---|
| 1800 Ninth Avenue<br>Seattle, WA 98101-1322<br>1-866-240-9580 or www.regence.com | 320 Westlake Avenue, Suite 100<br>Seattle, WA 98109-5233<br>1-888-901-4636 or www.ghc.org | P.O. BOX 75983<br>Seattle, WA 98175<br>1-800-554-1907 or www.deltadentalwa.com | 6950 NE Campus Way<br>Hillsboro, OR 97124-5611<br>1-855-433-6825 or www.willamettedental.com |

IMPORTANT: *Not Completely Filing Out This Section Could Result In A Denial Of Claims*

Other Healthcare Coverage

Do you or any of your dependents applying for coverage have coverage with any other Medical Plan (now, or in the past 6 months)? ☐ No ☐ Yes
If you answered YES to this question, please complete the following information.

*Medical:*

Name and address of insurer:_____

Name of policy holder:_____ Birthdate:_____ Date Coverage Began:_____ Date Coverage Ended:_____ Mos. Covered_____

Family members covered:

Name:_____ Date Coverage Began:_____ Date Coverage Ended:_____ Mos. Covered_____
Name:_____ Date Coverage Began:_____ Date Coverage Ended:_____ Mos. Covered_____
Name:_____ Date Coverage Began:_____ Date Coverage Ended:_____ Mos. Covered_____

*Dental:*

Name and address of insurer:_____

Name of policy holder:_____ Birthdate:_____ Date Coverage Began:_____ Date Coverage Ended:_____ Mos. Covered_____

Family members covered:

Name:_____ Date Coverage Began:_____ Date Coverage Ended:_____ Mos. Covered_____
Name:_____ Date Coverage Began:_____ Date Coverage Ended:_____ Mos. Covered_____
Name:_____ Date Coverage Began:_____ Date Coverage Ended:_____ Mos. Covered_____

If any dependent children are covered under another plan and the natural parents are divorced or separated, Washington State regulations require that we ask the following:
Name of parent with custody (indicate if parents have dual custody):_____
If divorced, did the court establish financial responsibility for the child(ren)'s health care? ☐ Yes ☐ No If yes, please specify the name and address of the parent with responsibility:

Name:_____ Address:_____

*Release & Authorization*

I **hereby apply** for coverage under the contract between the respective insurance company and my employer and the City of Tacoma and I agree with the terms of the contract. I also apply for the same coverage for my spouse, domestic partner, and/or dependent children listed on this application. I certify that my dependents and I meet all the eligibility criteria set forth in the outline or benefits and/or the Contract.

I **hereby verify** that all of the information specified on this form is accurate and complete. By signing below, I have authorized the release of information on for myself and my dependents listed on this form to the carriers (listed on back of this form) that cover me and my family members (if applicable).

I **acknowledge and understand** my health plan may request or disclose health information about me or my dependents (persons who are eligible for benefits coverage and are listed on the enrollment form) for the purpose of facilitating health-care treatment payment or for the purpose of business operations necessary to administer health-care benefits; or as required by law.*

Health information requested or disclosed may be related to treatment or services performed by: A physician, dentist, pharmacist or other physical or behavioral health care practitioner; A clinic, hospital, long-term care or other medical facility; Any other institution providing care, treatment, consultation, pharmaceuticals or supplies; or An insurance carrier or group health plan.

Health information requested or disclosed may include, but is not limited to: claims records, correspondence, medical records, billing statements, diagnostic imaging reports, laboratory reports, dental records, or hospital records (including nursing records and progress notes).

This acknowledgment does not apply to obtaining information regarding psychotherapy notes. A separate authorization will be used for psychotherapy notes.

For the protection of all of our members, fraud or misrepresentation of material fact by me for the purposes of defrauding the insurance company may result in the insurance company taking any action allowed by law or contract, including termination or rescission of coverage, denial of benefits, and/or pursuit of criminal charges and penalties.

**For more information about such uses and disclosures, including uses and disclosures required by law, please refer to the individual insurance carrier Consumer Privacy Notices by contacting the carrier directly.*