



# 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.	<input type="checkbox"/> Male	<input type="checkbox"/> Female	Date of Birth
				mm          dd          yyyy		
Mailing Address:				Phone Number		
City				Home (          ) -          Cell (          ) -		
State				Zip		Email _____

SECTION 2: Please Check Your Selections Below					
<b>Medical Plan                      Group #10010327</b> <i>TERS Retiree {SG 0003}</i> <input type="checkbox"/> Regence PPO [MESA 1001](CL 0005) <input type="checkbox"/> Regence HDHP [MHSA 1001](CL 0005) <i>LEOFF II Retiree {SG 0003}</i> Regence PPO Plan [MESA 3001] (CL 0006) <input type="checkbox"/> [MESA 1101] (CL 0007) <input type="checkbox"/> [MESA 1301] (CL 0008) <input type="checkbox"/> Regence High-Deductible HDHP [MHSA 1001] (CL 0006) <input type="checkbox"/> [MHSA 1001] (CL 0007) <input type="checkbox"/> Kaiser PPO Plan (Local 6 only) <input type="checkbox"/>	<b>Medical Plan                      Group #10010327</b> <i>LEOFF I Retiree {SG 0003}</i> Regence PPO - <u>Under 65</u> [MENG 5001] (CL 0009) <input type="checkbox"/> [MENG 5001] (CL 0011) <input type="checkbox"/> Regence PPO - <u>Over 65</u> [MENG 4001] (CL 0009) <input type="checkbox"/> [MENG 4001] (CL 0011) <input type="checkbox"/> [MENG 6001] (CL 0011) <input type="checkbox"/> Regence PPO - Retiree Dependents {SG 0004} [MESA 6001] (CL 0013) <input type="checkbox"/> [MESA 8001](CL 0013) <input type="checkbox"/> Regence PPO - Retiree Dependents {SG 0004} [MESA 6001] (CL 0014) <input type="checkbox"/> [MESA 8001] (CL 0014) <input type="checkbox"/>	<b>Dental Plans                      TERS Retiree (ONLY)</b> <input type="checkbox"/> Delta Dental of WA (00205) <input type="checkbox"/> Willamette Dental of WA, Inc. (WA142) <input type="checkbox"/> New Enrollment <input type="checkbox"/> Cancel Enrollment <input type="checkbox"/> Open Enrollment <input type="checkbox"/> Add Dependent <input type="checkbox"/> Drop Dependent <input type="checkbox"/> Address Change <input type="checkbox"/> Name Change <input type="checkbox"/> Other (list below) _____ <b>EFFECTIVE DATE</b> _____			

SECTION 3: DEPENDENT INFORMATION - SPOUSE / DOMESTIC PARTNER (Use additional forms to list additional dependents)							
<input type="checkbox"/> Spouse	<input type="checkbox"/> Domestic Partner	Last Name	First Name	MI	Social Security Number	Date of Birth	Gender <input type="checkbox"/> M <input type="checkbox"/> F
<input type="checkbox"/> Add <input type="checkbox"/> Drop							
<input type="checkbox"/> Medical <input type="checkbox"/> Dental		Date of Marriage/Partnership: _____					

CHILD / CHILDREN							
<input type="checkbox"/> Add	<input type="checkbox"/> Drop	Last Name	First Name	MI	Social Security Number	Date of Birth	Gender <input type="checkbox"/> M <input type="checkbox"/> F
<input type="checkbox"/> Medical <input type="checkbox"/> Dental							
<input type="checkbox"/> Add	<input type="checkbox"/> Drop	Last Name	First Name	MI	Social Security Number	Date of Birth	Gender <input type="checkbox"/> M <input type="checkbox"/> F
<input type="checkbox"/> Medical <input type="checkbox"/> Dental							

SECTION 4: SIGNATURE OF RETIREE	
_____	<b>Date</b> _____

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

<b>TERS Retiree</b> Retirement Department PO Box 11007, Tacoma, WA 98411-0007 Phone: (253) 502-8200 Fax: (253) 502-8660	<b>LEOFF I Retiree</b> Retirement Department PO Box 11001, Tacoma, WA 98411-0001 Phone: (253) 502-8700 Fax: (253) 502-8660	<b>LEOFF II Retiree</b> Human Resources Department 747 Market St Rm 1420, Tacoma, WA 98402 Phone: (253) 573-2345 Fax: (253) 591-5873	<b>Retiree Pension Plan</b> _____  <b>Date of Retirement</b> ____/____/____
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<b>Regence BlueShield</b> 1800 Ninth Avenue Seattle, WA 98101-1322 1-866-240-9580 or www.regence.com	<b>Kaiser Permanente</b> 320 Westlake Avenue, Suite 100 Seattle, WA 98109-5233 1-888-901-4636 or www.kp.org/wa	<b>Delta Dental of Washington</b> P.O. BOX 75983 Seattle, WA 98175 1-800-554-1907 or www.deltadentalwa.com	<b>Willamette Dental of Washington</b> 6950 NE Campus Way Hillsboro, OR 97124-5611 1-855-433-6825 or www.willamettedental.com
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**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.