CITY OF TACOMA
Group Insurance Plan Enrollment/Change Form
Retiree Only

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)*
☐ Regence HDHP *(MHSA 1001)*

LEOFF II Retiree *{SG 0003}*

Regence PPO *(MESA 3001)*	Regence HDHP *(MHSA 1001)*
L31 (CL 0006) ☐	*L31 (CL 0006)* ☐
L26 (CL 0007) ☐	*L26 (CL 0007)* ☐
L6 (CL 0008) ☐	*L6 (CL 0008)* ☐

Medical Plan **Group #10010327**

LEOFF I Retiree *{SG 0003}*

Regence PPO - Under 65	Regence PPO - Over 65
[MENG 5001] (CL 0009) ☐	*[MENG 4001] (CL 0009)* ☐
[MENG 5001] (CL 0011) ☐	*[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

☐ Washington Dental Service
☐ Willamette Dental of Washington, Inc.

☐ New Enrollment ☐ Cancel Enrollment
☐ Open Enrollment ☐ Add Dependent
☐ Drop Dependent ☐ Transfer
☐ Name Change ☐ Address Change

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	☐ Male ☐ Female Date of Marriage/Partnership:
Child / Children						
☐ Add ☐ Drop ☐ Medical ☐ Dental	Last Name	First Name	MI	Social Security Number	Date of Birth	☐ Male ☐ Female
☐ Add ☐ Drop ☐ Medical ☐ Dental	Last Name	First Name	MI	Social Security Number	Date of Birth	☐ Male ☐ Female

SECTION 4: Signature of Retiree

Retiree Signature	**Date**

IMPORTANT NOTE: Please mail this form to the appropriate office at the address listed below

TERS Retiree	**LEOFF I Retiree**	**LEOFF II Retiree**	**Retiree Pension Plan** _____
Retirement Department PO Box 11007, Tacoma, WA 98411-0007 Phone: (253) 502-8200 Fax: (253) 502-8660	Retirement Department PO Box 11001, Tacoma, WA 98411-0001 Phone: (253) 502-8700 Fax: (253) 502-8660	Human Resources Department 747 Market St Rm 1420, Tacoma, WA 98402 Phone: (253) 591-5823 Fax: (253) 591-5873	**Date of Retirement** ____/____/____

Regence BlueShield	Group Health	Washington Dental Service	Willamette Dental of Washington, Inc.
1800 Ninth Avenue Seattle, WA 98101-1322	320 Westlake Avenue, suite 100 Seattle, WA 98109-5233	P.O. BOX 75983 Seattle, WA 98175	6950 NE Campus Way Hillsboro, OR 97124-5611

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 answer yes above, please complete the following:

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: _____

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: _____

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, 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 eligibility criteria set forth in the outline of 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 provide coverage to me and my family members (if applicable).

I acknowledge and understand that my health plan carrier 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 healthcare treatment payment or for the purpose of business operations necessary to administer healthcare 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 healthcare 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.*