



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.	<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

<p>Medical Plan Group #10010327</p> <p style="text-align: center;">TERS Retiree {SG 0003}</p> <p>Regence PPO [MESA 1001] <input type="checkbox"/></p> <p>Regence HDHP [MHSA 1001] <input type="checkbox"/></p> <p style="text-align: center;">LEOFF II Retiree {SG 0003}</p> <p>Regence PPO Regence HDHP</p> <p>[MESA 3001] (CL 0006) <input type="checkbox"/> [MHSA 1001] (CL 0006) <input type="checkbox"/></p> <p>[MESA 1501] (CL 0007) <input type="checkbox"/> [MHSA 1001] (CL 0007) <input type="checkbox"/></p> <p>[MESA 1301] (CL 0008) <input type="checkbox"/> [MHSA 1001] (CL 0008) <input type="checkbox"/></p>	<p>Medical Plan Group #10010327</p> <p style="text-align: center;">LEOFF I Retiree {SG 0003}</p> <p>Regence PPO - <u>Under 65</u> Regence PPO - <u>Over 65</u></p> <p>[MENG 5001] (CL 0009) <input type="checkbox"/> [MENG 4001] (CL 0009) <input type="checkbox"/></p> <p>[MENG 5001] (CL 0011) <input type="checkbox"/> [MENG 4001] (CL 0011) <input type="checkbox"/></p> <hr/> <p>Regence PPO – Retiree Dependents {SG 0004}</p> <p>[MESA 6001] (CL 0013) <input type="checkbox"/> [MESA 8001] (CL 0013) <input type="checkbox"/></p> <p>Regence PPO – Retiree Dependents {SG 0004}</p> <p>[MESA 6001] (CL 0014) <input type="checkbox"/> [MESA 8001] (CL 0014) <input type="checkbox"/></p>	<p>Dental Plans</p> <p style="text-align: center;">TERS Retiree</p> <p><input type="checkbox"/> Delta Dental of Washington</p> <p><input type="checkbox"/> Willamette Dental of Washington, Inc.</p> <hr/> <p><input type="checkbox"/> New Enrollment <input type="checkbox"/> Cancel Enrollment</p> <p><input type="checkbox"/> Open Enrollment <input type="checkbox"/> Add Dependent</p> <p><input type="checkbox"/> Drop Dependent <input type="checkbox"/> Transfer</p> <p><input type="checkbox"/> Name Change <input type="checkbox"/> Address Change</p> <p>EFFECTIVE DATE _____</p>
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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	<input type="checkbox"/> Male <input type="checkbox"/> Female
<input type="checkbox"/> Add <input type="checkbox"/> Drop						Date of Marriage/Partnership:
<input type="checkbox"/> Medical <input type="checkbox"/> Dental						
Child / Children						
<input type="checkbox"/> Add <input type="checkbox"/> Drop	Last Name	First Name	MI	Social Security Number	Date of Birth	<input type="checkbox"/> Male <input type="checkbox"/> Female
<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	<input type="checkbox"/> Male <input type="checkbox"/> Female
<input type="checkbox"/> Medical <input type="checkbox"/> Dental						

SECTION 4: Signature of Retiree

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

<p>TERS Retiree Retirement Department PO Box 11007, Tacoma, WA 98411-0007 Phone: (253) 502-8200 Fax: (253) 502-8660</p>	<p>LEOFF I Retiree Retirement Department PO Box 11001, Tacoma, WA 98411-0001 Phone: (253) 502-8700 Fax: (253) 502-8660</p>	<p>LEOFF II Retiree Human Resources Department 747 Market St Rm 1420, Tacoma, WA 98402 Phone: (253) 591-5823 Fax: (253) 591-5873</p>	<p>Retiree Pension Plan _____</p> <p>Date of Retirement ____/____/____</p>
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Regence BlueShield
1800 Ninth Avenue
Seattle, WA 98101-1322
(866) 240-9580

Delta Dental of Washington
400 Fairview Ave N, Suite 800
Seattle, WA 98109-5371
(800) 554-1907

Willamette Dental of Washington, Inc.
6950 NE Campus Way
Hillsboro, OR 97124-5611
(855) 433-6825

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.