Washington Counties Insurance Fund
Retiree Medical Insurance Plan Enrollment Form
Underwritten by: United American Insurance Company

You Must Return Your Enrollment Form to Put Your Coverage In Force!

☐ Enhanced - Plan F ($406.00) ☐ Standard - Plan G ($285.00)

Please Print

Retiree Information:

Name: ____ Date of Birth: Month _______/Day_________/Year________

Address: ______________________________________ Social Security Number: _______ - ______ - _____________

City: ____ Medicare Number: __________________________________

State: __________ Zip Code: __________ Sex: _______ Phone Number: (________) __________________________

Desired Effective Date: ___________________________ Email Address: ____________________________________

Spouse Information:

Name: ____ Date of Birth: Month _______/Day_________/Year________

Address: ______________________________________ Social Security Number: _______ - ______ - _____________

City: ____ Medicare Number: __________________________________

State: __________ Zip Code: __________ Sex: _______ Phone Number: (________) __________________________

Desired Effective Date: ___________________________ Email Address: ____________________________________

Please Choose Type of Coverage:

☐ Retiree ☐ Retiree and Spouse ☐ Spouse Only

Please Complete:

Do you currently have any Medicare Supplement policies or certificates in force (including Health Maintenance Organization contract or Health care service contract)?

Retiree (if enrolling): ☐ Yes ☐ No **Spouse (if enrolling):** ☐ Yes ☐ No

(a) If YES* with which company? ____

(b) What kind of policy/certificate? ____

(c) Length of time you have had coverage? _____________Years ________ Months

(d) Will you be replacing the above listed policy/certificate upon acceptance of this enrollment form? ☐ Yes ☐ No

*I understand it is my responsibility, if I desire to do so, to cancel my current coverage, if any, by notifying the Provider or Plan Administrator of such coverage.

Please Sign and Date:

I/We hereby enroll in the Washington Counties Insurance Fund Retiree Medical Insurance Plan issued by United American Insurance Company. I/We am/are age 65 or over and covered by Medicare Parts A & B. I/We understand this insurance will be effective on the date shown on the certificate schedule. I acknowledge I have read the fraud warning statement below where applicable.

FRAUD WARNING

AR, CO, KY, LA, ME, NM, OH, OK, RI, TN and WA Residents: Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a crime and may be subject to fines or confinement in prison.

DC Residents: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

MD Residents: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. FRD1000A.MD

NJ Residents: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

PA Residents: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Retiree Signature: ____________________________________ Date: ____________________________________

Spouse Signature: ____________________________________ Date: ____________________________________

Mail your completed enrollment form in the return envelope provided.

For customer service: call 1-800-236-4782
Monday through Friday, 8:00 a.m. to 5:30 p.m., Eastern Time.