Washington Counties Insurance Fund
Administered by Benefit Solutions, Inc.
PO Box 6
Mukilteo WA 98275-0006
(206) 859-2600

2015 DRS Retirement Deduction Authorization Form

Please complete and return form to Benefit Solutions, Inc. (BSI)

Name (Last) (First) (Middle Initial)			Social Security #
Address (Street)			Date of Birth
City	State	Zip	Phone Number
Gender ☐ Male ☐ Female	Former Employer		Date Active Coverage Ended

Select plan(s) to be deducted from your monthly DRS check:

Medical	**Dental**	**Vision**
☐ Myself Only ☐ Myself & Eligible Dependent(s) ☐ Eligible Dependent(s) Only ☐ Decline	☐ Myself Only ☐ Myself & Eligible Dependent(s) ☐ Eligible Dependent(s) Only ☐ Decline	☐ Myself Only ☐ Myself & Eligible Dependent(s) ☐ Eligible Dependent(s) Only ☐ Decline
☐ United American Insurance Company **Enhanced – Plan F** (3181) ☐ United American Insurance Company **Standard – Plan G** (3181) ☐ Premera WCIF 750 PPO Plan (3231) ☐ Premera WCIF 3000 PPO Plan (3231) ☐ Group Health HMO 750 (3031)	☐ Delta Dental of Washington (3074) ☐ Willamette Dental of Washington (3318)	☐ Vision Service Plan (3081)
Please note: You are responsible for notifying WCIF when you or your spouse reach age 65, or in the event of either's death, change of address, and other changes in status. Please allow us 45 days to process.		

Please sign and date below:

I authorize the Department of Retirement Systems (DRS) to regularly deduct a sufficient amount from my retirement benefit to pay the premiums for my insurance coverage. I will not hold DRS responsible for any problems on coverage or premium charges that occur between the insurance carrier and myself.

The deductions will continue until:

- I notify in writing the plan administrator (BSI) and DRS, asking for my deductions to stop; or
- I terminate the insurance plan.

I understand that DRS cannot answer questions about my insurance.

Name:	
Signature:	
Date Signed:	