



Washington Counties Insurance Fund  
 Administered by Benefit Solutions, Inc.  
 PO Box 6  
 Mukilteo WA 98275-0006  
 (206) 859-2691

**2018 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 <input type="checkbox"/> Male <input type="checkbox"/> Female	Former Employer				Date Active Coverage Ended

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

Medical	Dental	Vision
<input type="checkbox"/> Myself Only <input type="checkbox"/> Myself & Eligible Dependent(s) <input type="checkbox"/> Eligible Dependent(s) Only <input type="checkbox"/> Decline	<input type="checkbox"/> Myself Only <input type="checkbox"/> Myself & Eligible Dependent(s) <input type="checkbox"/> Eligible Dependent(s) Only <input type="checkbox"/> Decline	<input type="checkbox"/> Myself Only <input type="checkbox"/> Myself & Eligible Dependent(s) <input type="checkbox"/> Eligible Dependent(s) Only <input type="checkbox"/> Decline
<input type="checkbox"/> United American Insurance Company <b>Plan F (3181)</b> <input type="checkbox"/> United American Insurance Company <b>High Deductible Plan F (3181)</b> <input type="checkbox"/> Premera WCIF 750 PPO Plan (3231) <input type="checkbox"/> Premera WCIF 3000 PPO Plan (3231) <input type="checkbox"/> Kaiser HMO 750 (3031) <input type="checkbox"/> Kaiser HMO 5000 (3031) <input type="checkbox"/> Kaiser Access PPO 5000 (3031)	<input type="checkbox"/> Delta Dental of Washington (3074) <input type="checkbox"/> Willamette Dental of Washington (3318)	<input type="checkbox"/> 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:	