2010 DRS Retirement Deduction Authorization Form

Last Name: _____ First Name: _____ Middle Initial: ____

Social Security #: _____

Street Address: _____

Date of Birth: _____

City: _____ State: _____ Zip: _____

Phone #: _____

☐ Male ☐ Female Former Employer: _____

Date Active Coverage Ended: _____

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

Medical	Dental	Vision
☐ Sterling Medical (3181)	☐ Washington Dental Service (3074)	☐ Vision Service Plan (3081)
☐ AfFOURdable PPO (1212)	Benefit Coverages:	Benefit Coverages:
☐ Budget PPO (1212)	☐ Myself	☐ Myself
☐ Group Health Options (3031)	☐ Myself & Eligible Dependents	☐ Myself & Eligible Dependents
☐ Kaiser (3117)	☐ Decline	☐ Decline
Benefit Coverages:		
☐ Myself		
☐ Myself & Eligible Dependents		
☐ Decline		

You are responsible for notifying the Washington Counties Insurance Fund/Pool when you or your spouse reach the age of 65, or in the event of either death, change of address, and other changes in status. Please allow 45 days for processing.

Please complete for DRS Retirement Check Deduction

This form is an authorization for payroll deductions for health insurance only. I _____ do hereby declare that to the best of my knowledge, I am eligible for coverage requested. I authorize the Department of Retirement Systems to deduct from my pension any premium I am requested to pay. This form supersedes all previous forms I have submitted for coverage.

Applicants Signature: _____ Date: _____

PRINT AND RETURN FORM TO:
WASHINGTON COUNTIES INSURANCE FUND/POOL, ATTN - Zenith Administrators
201 Queen Anne Avenue North, Suite 100, Seattle, WA 98109
FAX: (206) 217-0806

Medical Plan Code: _____ Premium: _____

Dental Plan Code: _____ Premium: _____

Vision Plan Code: _____ Premium: _____

FOR WCIF/WCIP USE ONLY

WCIF/WCIP Signature: _____ Effective Date: _____

WCIF / WCIP
Washington Counties Insurance Fund / Washington Counties Insurance Pool