2018 RETIREE BENEFIT ENROLLMENT & CHANGE FORM

FOR RETIREES OF WCIF PARTICIPATING EMPLOYERS

WCIF
WASHINGTON COUNTIES
INSURANCE FUND

INSTRUCTIONS:

Complete and mail (or email) this form to the following contact to enroll and/or register changes in your and/or your dependents' WCIF benefits

Benefit Solutions, Inc. (BSI)
PO Box 6
Mukilteo, WA 98275

wcif@bsitpa.com

Enrollment forms must be received within 60 days of termination of active group coverage.
Note: There cannot be a gap in coverage when electing retiree benefits.

THIS WILL REPLACE ANY BENEFIT ENROLLMENT INFORMATION YOU HAVE SUBMITTED IN THE PAST.

Effective Date:	

THIS IS AN APPLICATION FOR **(check one):**

☐ **New Retiree** ☐ **New Dependent** ☐ **Change in Status**

SECTION I: RETIREE INFORMATION

Last Name:	First Name:	Middle Initial:	Social Security #:

Gender: ☐ Male ☐ Female	Date of Birth:	Check as applicable: ☐ LEOFF I Retiree ☐ Disabled (eligible for Medicare by reason of disability)

Address:	City:	State:	Zip:	Email Address:

Primary Phone *(mandatory)*:	Alternate Phone:	Status: ☐ Single ☐ Married ☐ Qualified Domestic Partnership

RETIREE NAME:

SECTION II: DEPENDENT ENROLLMENT

Dependents who are eligible for WCIF coverage include:
- A lawful spouse/qualified domestic partner and
- Children to age 26 including biological, step, foster, adopted children from the date of assumption of legal obligation for total or partial support, children required by court order or qualified medical child support order (QMCSO) to be covered by a participant.

SPOUSE/QUALIFIED DOMESTIC PARTNER INFORMATION

Last Name:	First Name:	Middle Initial:
Social Security #:	Gender: ☐ Male ☐ Female	Date of Birth:
☐ Same as Retiree Address:	City:	State: Zip:

CHILD INFORMATION

1. Last Name:	First Name:	Middle Initial:
Social Security #:	Gender: ☐ Male ☐ Female	Date of Birth:
☐ Address Same as Retiree Address (if different):	City:	State: Zip:
2. Last Name:	First Name:	Middle Initial:
Social Security #:	Gender: ☐ Male ☐ Female	Date of Birth:
☐ Address Same as Retiree Address (if different):	City:	State: Zip:

For additional dependent(s) please attach a separate sheet of paper.

SECTION III: PLAN ELECTION

Under Age 65: Medical
1. Employee must have formally declared retirement, and
2. Must have been enrolled with the same carrier in the WCIF active (and/or COBRA) medical plan immediately prior to enrollment in the retiree plan (i.e. active employees who were Premera medical participants immediately prior to enrollment in the retiree plan are only eligible for the Premera retiree plan(s). Likewise, active employees who were Kaiser Permanente medical participants are only eligible to enroll in the Kaiser Permanente retiree plan(s); which Kaiser Permanente retiree plan(s) are available is based upon the Kaiser Permanente network offered by the former employer.

Over Age 65: Medical (Medicare Supplement)
1. Employee must have formally declared retirement, and
2. Must have participated in a WCIF plan as an active employee, and
3. Must be over 65 and enrolled in Medicare Parts A and B.

Under & Over Age 65: Dental and/or Vision
1. Employee must have formally declared retirement, and
2. Must have been enrolled with the same carrier(s) in the WCIF active dental and/or vision (and/or COBRA) plan(s) immediately prior to enrollment in the retiree plan (i.e. active employees who were Delta Dental participants immediately prior to enrollment in the retiree plan are only eligible for Delta Dental retiree plan. Likewise, active employees who were Willamette Dental participants are only eligible for retiree coverage through Willamette. Also, active employees enrolled on a VSP vision plan will be eligible for retiree coverage through VSP.)

RETIREE NAME:

MEDICAL

☐ **I DECLINE THIS COVERAGE**

☐ For myself only ☐ For myself & my spouse* ☐ For myself, spouse* & children

☐ For my spouse* only ☐ For myself & my children

PLAN	REQUIREMENTS
☐ **Kaiser Permanente Core (HMO) 750 Plan**	1. **Must be age 64 or under** 2. Must be enrolled in a WCIF Kaiser Permanente plan as an active employee (see Section III: Plan Election for possible restrictions)
☐ **Kaiser Permanente Access PPO 5000 Plan**	1. **Must be age 64 or under** 2. Must be enrolled in a WCIF Kaiser Permanente plan as an active employee (see Section III: Plan Election for possible restrictions)
☐ **Premera Blue Cross WCIF 3000 PPO Plan**	1. **Must be age 64 or under** 2. Must be enrolled in a WCIF Premera PPO plan as an active employee.
☐ **Premera Blue Cross WCIF 750 PPO Plan**	1. **Must be age 64 or under** 2. Must be enrolled in a WCIF Premera PPO plan as an active employee.
☐ **Premera Blue Cross WCIF 200 PPO Plan** *LEOFF I Retirees Only*	1. **Must be a LEOFF I retiree** 2. **Must be age 64 or under** 3. Must be enrolled in a WCIF Premera PPO plan as an active employee.
☐ **United American Insurance Company** (Supplement Plans & Medicare Part D Rx coverage through Express Scripts) ☐ **Enhanced** (Plan F) ☐ **Standard** (Plan G)	1. **Must be age 65 or over** 2. Must be enrolled in Medical Parts A and B 3. Must complete additional enrollment forms (see United American Medicare Supplement Program Packet for additional forms)

DENTAL

☐ **I DECLINE THIS COVERAGE**

☐ **Delta Dental of Washington**

☐ **Willamette Dental of Washington Inc**

☐ For myself only

☐ For my spouse* only

☐ For myself & my spouse*

☐ For myself & my children

☐ For myself, spouse* & children

VISION

☐ **I DECLINE THIS COVERAGE**

☐ **VSP Vision Care, Inc.**

☐ For myself only

☐ For my spouse* only

☐ For myself & my spouse*

☐ For myself & my children

☐ For myself, spouse* & children

SECTION IV: OTHER COVERAGE **(FOR WCIF PRE-65 MEDICAL PARTICIPANTS ONLY)**

Are you and/or your dependents currently enrolled in other medical coverage?

☐ **Yes** *(if checked, complete the following)* ☐ **No** *(if checked, proceed to SECTION V)*

The following has other medical coverage:

☐ **Self** ☐ **Spouse*** ☐ **Child Dependent #1** ☐ **Child Dependent #2**

Other Coverage:	Subscriber Name:	Plan Phone #:	Coverage Start Date:	Coverage End Date:
2nd Other Coverage:	Subscriber Name:	Plan Phone #:	Coverage Start Date:	Coverage End Date:

RETIREE NAME:

SECTION V: CHANGE INFORMATION **(FOR EXISTING RETIREES ONLY)**

Select from the following to change your existing enrollment information. | **Effective Date:**

☐ ADDITION **of employee and/or dependent(s) coverage due to:**

☐ Newly acquired child due to birth, adoption, foster care placement, legal guardianship, or marriage + Attach documentation as appropriate	☐ Marriage* + Attach copy of marriage certificate
☐ Court order or qualified medical child support order (QMCSO) + Attach copy of QMCSO	☐ Loss of other comparable group coverage

☐ TERMINATION / DROP **of dependent(s) coverage due to:**

☐ Divorce**	☐ Loss of eligibility for WCIF coverage
☐ Legal separation	☐ Anticipation of divorce

☐ **OTHER | EXPLANATION:**

** Or qualified domestic partner | ** Or termination/dissolution of domestic partnership*

SECTION VI: SIGNATURE

By signing this form, I declare that the information I have provided is true, complete, and correct. I understand that it is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits. WCIF may verify eligibility for myself and my family members. This form replaces all previous forms and submissions I have made for WCIF benefits.

Retiree's Signature: _____ Date: _____

Premera Blue Cross
7001 220th St SW
Mountlake Terrace, WA 98403
To obtain plan number unique to your employer contact WCIF at (800) 344-8570.

Delta Dental of Washington
9706 4th Ave NE
Seattle, WA 98115
00497 00498 00500
00501 00502 00478

VSP Vision Care, Inc.
3333 Quality Drive
Rancho Cordova, CA 95670
30029829

Kaiser Foundation Health Plan of WA Options, Inc.
601 Union Street, Suite 3100
Seattle, WA 98101
To obtain plan number unique to your employer, contact WCIF at (800) 344-8570.

Willamette Dental of Washington Inc
6950 NE Campus Way
Hillsboro, OR 97124
WA204

Kaiser Foundation Health Plan
601 Union Street, Suite 3100
Seattle, WA 98101
To obtain plan number unique to your employer, contact WCIF at (800) 344-8570.

United American Insurance Company
(administered through Benistar)
10306 Regency Parkway Dr
Omaha, NE 68114-3743
Plan number unique to policy holder.

MAIL APPLICATION TO:
BENEFIT SOLUTIONS, INC. (BSI)
PO Box 6 • Mukilteo, Washington • 98275

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 ☐ 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 **Plan F** (3181) ☐ United American Insurance Company **High Deductible Plan F** (3181) ☐ Premera WCIF 750 PPO Plan (3231) ☐ Premera WCIF 3000 PPO Plan (3231) ☐ Kaiser HMO 750 (3031) ☐ Kaiser HMO 5000 (3031) ☐ Kaiser Access PPO 5000 (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:	