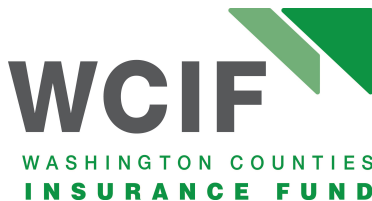


2021 RETREE BENEFIT ENROLLMENT & CHANGE FORM

FOR RETIREES OF WCIF PARTICIPATING EMPLOYERS



INSTRUCTIONS:

Complete and mail (or email) this form to enroll and/or register changes in your and/or your dependent(s) WCIF benefits.

Vimly, Inc.
PO Box 6
Mukilteo, WA 98275

wcif@vimly.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.

Coverage Effective Date

THIS IS AN APPLICATION FOR (check one):

New Retiree New Dependent Change in Status

SECTION I: EMPLOYEE INFORMATION

Last Name:		First Name:		Middle Initial:	Social Security #:	
Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male	Date of Birth:	Check as applicable: <input type="checkbox"/> LEOFF I Retiree <input type="checkbox"/> Disabled (eligible for Medicare by reason of disability)				
Physical Address (mandatory):			City:	State:	Zip:	
Mailing Address (if different than physical address):			City:	State:	Zip:	
Primary Phone (mandatory):	Alternate Phone:	Status: <input type="checkbox"/> Single <input type="checkbox"/> Qualified Domestic Partnership <input type="checkbox"/> Married				
Email Address:		Former WCIF Employer:				

RETIREE NAME: _____

SECTION II: CHANGE INFORMATION (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, marriage, or domestic partnership
+ Attach documentation as appropriate

Marriage or qualified Domestic Partnership
+ Attach copy of Marriage Certificate or Qualified Domestic Partnership

Court order or qualified medical child support order (QMCSO) + Attach copy of QMCSO

Loss of other 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 termination/dissolution of domestic partnership

SECTION III: DEPENDENT ENROLLMENT

(Washington State Registered Domestic Partners are treated the same as a spouse.)

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: <input type="checkbox"/> Female <input type="checkbox"/> Male	Date of Birth:
Address: <input type="checkbox"/> Same as Retiree If different: _____	City:	State: Zip:

CHILD(REN) INFORMATION

1. Last Name:	First Name:	Middle Initial:
Social Security #:	Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male	Date of Birth:
Address: <input type="checkbox"/> Same as Retiree If different: _____	City:	State: Zip:
2. Last Name:	First Name:	Middle Initial:
Social Security #:	Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male	Date of Birth:
Address: <input type="checkbox"/> Same as Retiree If different: _____	City:	State: Zip:

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

RETIREE NAME: _____

SECTION IV: PLAN ELECTION

MEDICAL

I DECLINE THIS COVERAGE

- For myself only
 For myself & my spouse/domestic partner
 For myself, spouse/domestic partner & child(ren)
 For my spouse/domestic partner only
 For myself & my child(ren)

PLAN	REQUIREMENTS
<input type="checkbox"/> Kaiser Foundation Health Plan of WA Core (HMO) 750 Plan	<ol style="list-style-type: none"> 1. Must be under age 65 2. Must be enrolled in a WCIF Kaiser Permanente plan as an active employee (see Section III: Plan Election for possible restrictions)
<input type="checkbox"/> Kaiser Foundation Health Plan of WA Options, Inc. Access PPO 5000 Plan	<ol style="list-style-type: none"> 1. Must be under age 65 2. Must be enrolled in a WCIF Kaiser Permanente plan as an active employee (see Section III: Plan Election for possible restrictions)
<input type="checkbox"/> Kaiser Foundation Health Plan of WA Core (HMO) 5000 Plan	<ol style="list-style-type: none"> 1. Must be under age 65 2. Must be enrolled in a WCIF Kaiser Permanente plan as an active employee (see Section III: Plan Election for possible restrictions)
<input type="checkbox"/> Premera Blue Cross WCIF 3000 PPO Plan	<ol style="list-style-type: none"> 1. Must be under age 65 2. Must be enrolled in a WCIF Premera PPO plan as an active employee.
<input type="checkbox"/> Premera Blue Cross WCIF 750 PPO Plan	<ol style="list-style-type: none"> 1. Must be under age 65 2. Must be enrolled in a WCIF Premera PPO plan as an active employee.
<input type="checkbox"/> Premera Blue Cross WCIF 200 PPO Plan <i>LEOFF I Retirees Only</i>	<ol style="list-style-type: none"> 1. Must be a LEOFF I retiree 2. Must be under age 65 3. Must be enrolled in a WCIF Premera PPO plan as an active employee.
United American Insurance Company <input type="checkbox"/> Plan F <input type="checkbox"/> High Deductible Plan F <input type="checkbox"/> Plan G	<ol style="list-style-type: none"> 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) 4. Must be eligible (age 65) prior to 1/1/2021 to elect Plan F

DENTAL

I DECLINE THIS COVERAGE

VISION

I DECLINE THIS COVERAGE

- Delta Dental of Washington**
 Willamette Dental of Washington, Inc.
 For myself only
 For myself & my spouse/domestic partner
 For myself & my child(ren)
 For myself, spouse/domestic partner & child(ren)

- VSP Vision Care, Inc.**

 For myself only
 For myself & my spouse/domestic partner
 For myself & my child(ren)
 For myself, spouse/domestic partner & child(ren)

SECTION V: OTHER COVERAGE (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 VI)

The following has other medical coverage:

- Self**
 Spouse / Domestic Partner
 Child Dependent #1
 Child Dependent #2

Other Coverage:	Subscriber Name:	Plan Phone #:	Coverage Start Date:	Coverage End Date:
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RETIREE NAME: _____

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 Signature: _____

Date: _____

Premera Blue Cross

7001 220th St SW
Mountlake Terrace, WA 98043
To obtain plan number unique to your employer
contact WCIF at (800) 344-8570.
Premera Blue Cross is an independent licensee
of the Blue Cross Blue Shield Association.

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.

Kaiser Foundation Health Plan of WA

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

Delta Dental of Washington

400 Fairview Avenue N, Suite 800
Seattle, WA 98109
00497 00498 00500
00501 00502 00478

Willamette Dental of Washington, Inc.

6950 NE Campus Way
Hillsboro, OR 97124
WA204

VSP Vision Care, Inc.

3333 Quality Drive
Rancho Cordova, CA 95670 30029829

Standard Insurance Company

1100 SW 6th Ave
Portland, OR 97204
645273

First Choice Health EAP

600 University Street, Suite 1400
Seattle, WA 98101

United American Insurance Company

10306 Regency Parkway Dr
Omaha, NE 68114-3743
To obtain plan number unique to you
contact Benistar at (800) 236-4782

RETURN SIGNED APPLICATION TO:

**VIMLY, Inc.
PO Box 6
Mukilteo, Washington 98275**