2022 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 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: ☐ Female ☐ Male	Date of Birth:	Check as applicable: ☐ LEOFF I Retiree ☐ 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: ☐ Single ☐ Married ☐ Qualified Domestic Partnership
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	☐ Other:

**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: ☐ Female ☐ Male	Date of Birth:	
Address: ☐ Same as Retiree If different: _____	City:	State:	Zip:

CHILD(REN) INFORMATION

1. Last Name:	First Name:		Middle Initial:
Social Security #:	Gender: ☐ Female ☐ Male	Date of Birth:	
Address: ☐ Same as Retiree If different: _____	City:	State:	Zip:
2. Last Name:	First Name:		Middle Initial:
Social Security #:	Gender: ☐ Female ☐ Male	Date of Birth:	
Address: ☐ 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
☐ **Kaiser Foundation Health Plan of WA Core (HMO) 750 Plan**	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)
☐ **Kaiser Foundation Health Plan of WA Options, Inc. Access PPO 5000 Plan**	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)
☐ **Kaiser Foundation Health Plan of WA Core (HMO) 5000 Plan**	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)
☐ **Premera Blue Cross WCIF 3000 PPO Plan**	1. **Must be under age 65** 2. Must be enrolled in a WCIF Premera PPO plan as an active employee.
☐ **Premera Blue Cross WCIF 750 PPO Plan**	1. **Must be under age 65** 2. Must be enrolled in a WCIF Premera PPO plan as an active employee.
☐ **Premera Blue Cross WCIF 200 PPO Plan**	1. **Must be under age 65** 2. Must be enrolled in a WCIF Premera PPO plan as an active employee.
United American Insurance Company/United Healthcare ☐ Plan F / Rx Plan A ☐ High Deductible Plan G / Rx Plan A ☐ Plan F / Rx Plan B ☐ Plan G / Rx Plan A ☐ High Deductible Plan G / Rx Plan B ☐ Plan G / Rx Plan B	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

☐ **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)

VISION ☐ I DECLINE THIS COVERAGE

☐ **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:	Subsciber Name:	Plan Phone #:	Coverage Start Date:	Coverage End Date:

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.
1300 SW 27th St
Renton, WA 98057
To obtain plan number unique to your employer contact WCIF at (800) 344-8570.

Kaiser Foundation Health Plan of WA
1300 SW 27th St
Renton, WA 98057
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
Plan Numbers:
00497 00498 00500
00501 00502 00478

Willamette Dental of Washington, Inc.
6950 NE Campus Way
Hillsboro, OR 97124
Plan Number: WA204

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

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