



# CITY OF TACOMA

## Group Insurance Plan Enrollment/Change Form

### Retirees Only

#### SECTION 1: All Retirees Must Complete This Section

Social Security Number	Last Name	First Name	M.I.	<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth (mm/ dd/yyyy)
Mailing Address				Phone Number(s) / Email	
City				Home _____ Cell _____	
State				Zip	
Email _____					

#### SECTION 2: Please Check Your Selections Below

<p><b>Medical Plan Options</b>      <b>Regence Group #10010327</b></p> <p style="text-align: center;"><b>TERS Retirees {SG 0003}</b></p> <p><b>Regence PPO</b>      <b>Regence HDHP</b>          [MESA 1001] <input type="checkbox"/> TERS Retiree (CL 0001)    [MHSA 1001] <input type="checkbox"/></p> <p style="text-align: center;"><b>LEOFF II Retirees {SG 0003}</b></p> <p><b>Regence PPO</b>      <b>Regence HDHP</b>          [MESA 1001] <input type="checkbox"/> Police Local 6 (CL 0008)    [MHSA 1001] <input type="checkbox"/>          [MESA 1501] <input type="checkbox"/> Police Local 26 (CL 0007)    [MHSA 1001] <input type="checkbox"/>          [MESA 3001] <input type="checkbox"/> Fire Local 31 (CL 0006)    [MHSA 1001] <input type="checkbox"/>          [MESA 3001] <input type="checkbox"/> PPSMA (CL 0001)    [MHSA 1001] <input type="checkbox"/></p>	<p><b>Medical Plan Options</b>      <b>Regence Group #10010327</b></p> <p style="text-align: center;"><b>LEOFF I Retiree {SG 0003}</b></p> <p><b>Regence PPO - Under 65</b>      <b>Regence PPO - Over 65</b>          [MENG 5001] (CL 0009) <input type="checkbox"/>      [MENG 4001] (CL0009) <input type="checkbox"/>          [MENG 5001] (CL 0011) <input type="checkbox"/>      [MENG 4001] (CL 0011) <input type="checkbox"/></p> <p style="text-align: center;"><b>Regence PPO – Retiree Dependents {SG 0004}</b></p> <p>[MESA 6001] (CL 0013) <input type="checkbox"/>      [MESA 8001](CL 0013) <input type="checkbox"/>  <b>Regence PPO – Retiree Dependents {SG 0004}</b>          [MESA 6001] (CL 0014) <input type="checkbox"/>      [MESA 8001] (CL 0014) <input type="checkbox"/></p>	<p><b>Dental Plans</b>      <b>TERS Retirees</b></p> <p><input type="checkbox"/> Delta Dental of Washington  <input type="checkbox"/> Willamette Dental of Washington, Inc.</p> <p><input type="checkbox"/> New Enrollment      <input type="checkbox"/> Cancel Enrollment  <input type="checkbox"/> Open Enrollment      <input type="checkbox"/> Add Dependent  <input type="checkbox"/> Drop Dependent      <input type="checkbox"/> Transfer  <input type="checkbox"/> Name Change      <input type="checkbox"/> Address Change</p> <p><b>Effective Date:</b> _____</p>
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#### SECTION 3: Dependent Information – Spouse / Domestic Partner (Use additional forms to list additional dependents)

<input type="checkbox"/> Spouse	<input type="checkbox"/> Domestic Partner	Last Name	First Name	MI	Social Security Number	Date of Birth	<input type="checkbox"/> Male <input type="checkbox"/> Female
<input type="checkbox"/> Add	<input type="checkbox"/> Drop						
<input type="checkbox"/> Medical	<input type="checkbox"/> Dental						
<b>Child / Children</b>							
<input type="checkbox"/> Add	<input type="checkbox"/> Drop	Last Name	First Name	MI	Social Security Number	Date of Birth	<input type="checkbox"/> Male <input type="checkbox"/> Female
<input type="checkbox"/> Medical	<input type="checkbox"/> Dental						
<input type="checkbox"/> Add	<input type="checkbox"/> Drop						
<input type="checkbox"/> Medical	<input type="checkbox"/> Dental						
<input type="checkbox"/> Add	<input type="checkbox"/> Drop						
<input type="checkbox"/> Medical	<input type="checkbox"/> Dental						

#### SECTION 4: Signature of Retiree

Retiree Signature	Date
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**IMPORTANT NOTE: Please mail this form to the appropriate office at the address listed below**

<b>TERS Retiree</b> Retirement Department PO Box 11007, Tacoma, WA 98411-0007 Phone: (253) 502-8200 Fax: (253) 502-8660	<b>LEOFF I Retiree</b> Retirement Department PO Box 11001, Tacoma, WA 98411-0001 Phone: (253) 502-8700 Fax: (253) 502-8660	<b>LEOFF II Retiree</b> Human Resources Department 747 Market St Rm 1420, Tacoma, WA 98402 Phone: (253) 591-5823 Fax: (253) 591-5873	<b>Retiree Pension Plan</b> _____  <b>Date of Retirement</b> _____
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**Regence BlueShield**  
1800 Ninth Avenue  
Seattle, WA 98101-1322  
(866) 240-9580

**Delta Dental of Washington**  
400 Fairview Ave N, Suite 800  
Seattle, WA 98109-5371  
(800) 554-1907

**Willamette Dental of Washington, Inc.**  
6950 NE Campus Way  
Hillsboro, OR 97124-5611  
(855) 433-6825

**IMPORTANT: Not Completely Filing Out This Section Could Result in a Denial of Claims**

**Other Healthcare Coverage**

Do you or any of your dependents applying for coverage have coverage with any other Medical Plan (now, or in the past 6 months)?  No  Yes

If you answer yes above, please complete the following:

**Medical:**

Name and address of insurer: \_\_\_\_\_

Name of policy holder: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Date Coverage Began: \_\_\_\_\_ Date Coverage Ended: \_\_\_\_\_ Mos. Covered: \_\_\_\_\_

Family members covered:

Name: \_\_\_\_\_ Date Coverage Began: \_\_\_\_\_ Date Coverage Ended: \_\_\_\_\_ Mos. Covered: \_\_\_\_\_

Name: \_\_\_\_\_ Date Coverage Began: \_\_\_\_\_ Date Coverage Ended: \_\_\_\_\_ Mos. Covered: \_\_\_\_\_

**Dental:**

Name and address of insurer: \_\_\_\_\_

Name of policy holder: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Date Coverage Began: \_\_\_\_\_ Date Coverage Ended: \_\_\_\_\_ Mos. Covered: \_\_\_\_\_

Family members covered:

Name: \_\_\_\_\_ Date Coverage Began: \_\_\_\_\_ Date Coverage Ended: \_\_\_\_\_ Mos. Covered: \_\_\_\_\_

Name: \_\_\_\_\_ Date Coverage Began: \_\_\_\_\_ Date Coverage Ended: \_\_\_\_\_ Mos. Covered: \_\_\_\_\_

If any dependent children are covered under another plan and the natural parents are divorced or separated, Washington State regulations require that we ask the following:

Name of parent with custody (indicate if parents have dual custody): \_\_\_\_\_

If divorced, did the court establish financial responsibility for the child(ren)'s health care?  Yes  No If yes, please specify the name and address of the parent with responsibility:

Name: \_\_\_\_\_ Address: \_\_\_\_\_

**Release & Authorization**

**I hereby apply** for coverage under the contract between the respective insurance company and my employer, the City of Tacoma, and I agree with the terms of the contract. I also apply for the same coverage for my spouse, domestic partner, and/or dependent children listed on this application. I certify that my dependents and I meet all eligibility criteria set forth in the outline of benefits and/or the Contract.

**I hereby verify** that all of the information specified on this form is accurate and complete. By signing, I have authorized the release of information on for myself and my dependents listed on this form to the carriers (listed on this form) that provide coverage to me and my family members (if applicable).

**I acknowledge and understand** that my health plan carrier may request or disclose health information about me or my dependents (persons who are eligible for benefits coverage and are listed on the enrollment form) for the purpose of facilitating healthcare treatment payment or for the purpose of business operations necessary to administer healthcare benefits; or as required by law\*.

Health information requested or disclosed may be related to treatment or services performed by: a physician, dentist, pharmacist, or other physical or behavioral healthcare practitioner; a clinic, hospital, long-term care or other medical facility; any other institution providing care, treatment, consultation, pharmaceuticals, or supplies; or an insurance carrier or group health plan.

Health information requested or disclosed may include, but is not limited to: claims records, correspondence, medical records, billing statements, diagnostic imaging reports, laboratory reports, dental records, or hospital records (including nursing records and progress notes).

This acknowledgment does not apply to obtaining information regarding psychotherapy notes. A separate authorization will be used for psychotherapy notes.

For the protection of all of our members, fraud or misrepresentation of material fact by me for the purposes of defrauding the insurance company may result in the insurance company taking any action allowed by law or contract, including termination or rescission of coverage, denial of benefits, and/or pursuit of criminal charges and penalties.

\*For more information about such uses and disclosures, including uses and disclosures required by law, please refer to the individual insurance carrier Consumer Privacy Notices by contacting the carrier directly.