

## CITY OF TACOMA Group Insurance Plan Enrollment/Change Form Retirees Only

SECTION 1: All Retirees Must Complete This Section										
Social Security Number	curity Number Last Name		First Name N		I.I.	Male Female		Date of Birth (mm/dd/yyyy)		
Mailing Address				Phone Number(s) / En	nail					
						Home		Cell		
City State			7'			Email				
SECTION 2: Please Check Your Selections Below										
Medical Plan Options	Regence Gro	oup #10010327	Medical Plan Options	Re	egence	e Group #10010327	<b>Dental</b> P	ans		
TERS Retiree / RAIL Retiree {SG 0003}			LEOFF I Retiree {SG 0003}			}	TERS Retiree			
Regence PPO Regence HDHP		Regence PPO - <u>Under 65</u> Re			ence PPO - <u>Over 65</u> Delta Dental of Washington			e		
		MHSA 1001]	[MENG 5001] (CL 0009)	] [/	MENG	4001] (CL0009) 🗌	U Will	amette De	ental of Washington, Inc.	
[MESA 3001]			[MENG 5001] (CL 0011) [[MENG 4001] (CL 0011)			4001] (CL 0011) 🗌	New Enrollment Cancel Enrollment			
LEOFF II Retiree {SG 0003}										
Regence PPO Regence HDHP			Regence PPO – Retiree Dependents {SG 0004}			{SG 0004}	Open Enrollment Add Dependent			
[MESA 1301]  Police Local 6, CL 0008 [MHSA 1001]			[MESA 6001] (CL 0013) [[MESA 8001] (CL 0013)]			Drop Dependent Transfer   Name Change Address Change				
[MESA 1501]   Police Local 26, CL 0007 [MHSA 1001]			Regence PPO – Retiree Dependents <i>{SG 0004}</i>							
[MESA 3001]   Fire Local 31, CL 0006   [MHSA 1001]     [MESA 3001]   PPSMA, CL 0001   [MHSA 1001]			[MESA 6001] (CL 0014) [] [MESA 8001] (CL 0014) []			· · · · ·	_ • _ •			
[MESA 3001]	$[MESA \ 8001] \ (CL \ 0014) \ [MESA \ 8001] \ (CL \ 0014) \ [$			EFFECTIVE DATE						
SECTION 3: Dependent	Information –	Spouse / Dom	estic Partner <mark>(Use additio</mark>	nal forms	s to li	st additional depe	ndents)			
Spouse Domestic	e Partner Last N	Name	First Name	MI S	Social S	Security Number	Date of Bir	th	Male Female	
Add I	Drop								Non-Binary	
	Dental								Date of Marriage/Partnership:	
Child / Child	ren									
Add I	Prop Last N	Name	First Name	MI S	Social S	Security Number	Date of Bir	th	Male Female	
	Dental					-			Non-Binary	
Add	Drop Last N	Name	First Name	MI S	Social S	Security Number	Date of Bir	th	Male Female	
	Dental								Non-Binary	
SECTION 4: Signature	of Retiree							I		
Retiree Signature						Date				
-										
IMPORTANT NOTE: Please email or mail this form to the appropriate office at the address listed below										
			LEOFF I Retiree		LEOFF II / RAIL Retiree			Retiree Pension Plan		
		tirement Department 01, Tacoma, WA 98411-0001 7		Human Resources Departmen 747 Market St Rm 1420, Tacoma, W			Actil CC			
			502-8700 Fax: (253) 502-8660					Date of	Retirement	
TERSretirement@citvoftacoma.org					Benefits@citvoftacoma.org					

Regence BlueShield 1800 Ninth Avenue Seattle, WA 98101-1322 (855) 877-0047		Delta Dental of Washingt 400 Fairview Ave N, Suite Seattle, WA 98109-5371 (800) 554-1907	800	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:											
	Birthdate:	Date Coverage Began:	Date Coverage Ended:	Mos. Covered:							
Family members covered:		_									
Name:											
Name:	Date Coverage	Began:	_ Date Coverage Ended:	Mos. Covered:							
<u>Dental:</u>											
Name and address of insurer:											
Name of policy holder:E	Birthdate:	Date Coverage Began:	Date Coverage Ended:	Mos. Covered:							
Family members covered:		_									
Name:											
Name:	-	-	_ Date Coverage Ended:								
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 INo If yes, please specify the name and address of the parent with responsibility:											
Name:	Address:										
Release & Authorization											
	e respective insuranc	e company and my employer	the City of Tacoma, and Lagree with	the terms of the contract. Lalso apply for							
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 below, I have authorized the release of information on for myself and my dependents listed on this form to the carriers (listed on back of this form) that provide coverage to me and my family members (if applicable).											
I acknowledge and understand that my health plan carrie listed on the enrollment form) for the purpose of facilitating h law*.											
Health information requested or disclosed may be related to hospital, long-term care or other medical facility; any other in	treatment or services	s performed by: a physician, d re, treatment, consultation, ph	entist, pharmacist, or other physical armaceuticals, or supplies; or an insu	or behavioral healthcare practitioner; a clinic, irance carrier or group health plan.							
Health information requested or disclosed may include, but i dental records, or hospital records (including nursing records			nedical records, billing statements, dia	ignostic imaging reports, laboratory reports,							
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 re	equired by law, please refer to the	e individual insurance carrier Consumer F	Privacy Notices by contacting the carrier directly.							