



WASHINGTON COUNTIES INSURANCE FUND
WASHINGTON COUNTIES INSURANCE POOL

RETIREE BENEFIT ENROLLMENT & CHANGE FORM FOR RETIREES OF WCIF PARTICIPATING EMPLOYERS

Submit this form to the address at the bottom of the form to enroll and/or register changes in your and/or your dependents' WCIF benefits. **THIS WILL REPLACE ANY BENEFIT ENROLLMENT INFORMATION YOU MAY HAVE SUBMITTED IN THE PAST.**

THIS IS AN APPLICATION FOR (check one)

- Open Enrollment
 New Retiree
 New Dependent
 Status Change

Effective Date:

SECTION I: RETIREE INFORMATION

Name (First, Middle, Last):				Social Security Number:			
Gender:	<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth:	Check as applicable:	<input type="checkbox"/> LEOFF I Retiree <input type="checkbox"/> Disabled (eligible for Medicare by reason of disability)			
Address:	City:	State:	Zip:	Email Address:			
• You must provide at least one current phone number •				Status:	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Qualified Domestic Partnership		
Home Phone:	Cell Phone:						

SECTION II: CHANGE INFORMATION (FOR EXISTING RETIREES ONLY)

Select from the following to change your existing enrollment information.

Date of Event:

CHANGE

- Open Enrollment Name
 Address

ADDITION of employee and/or dependent coverage due to:

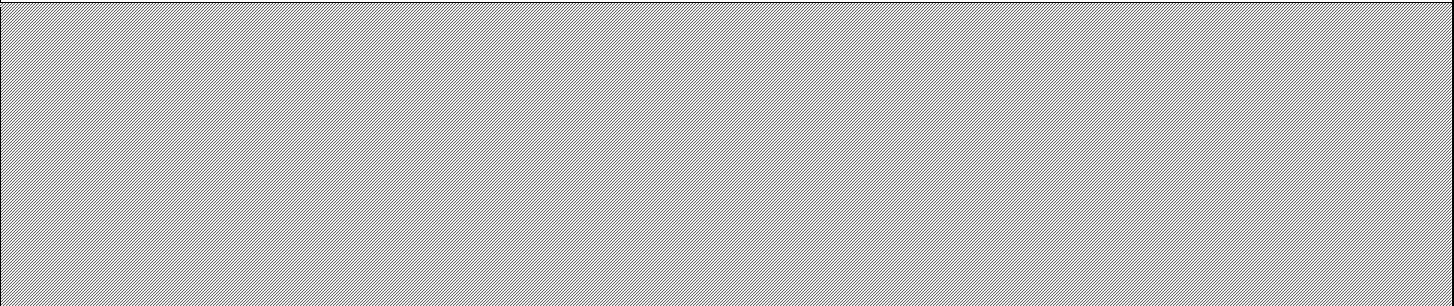
- Loss of other comparable group coverage
 + Attach copy of Certificate of Creditable Coverage Marriage**
 Newly acquired child due to birth, adoption, foster care placement, legal guardianship, or marriage Court order or qualified medical child support order (QMCSO) + Attach copy of QMCSO

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

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

OTHER – EXPLAIN:

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



CONTINUED ON NEXT PAGE →

Retiree Name (first and last): _____

SECTION III: PLAN ELECTION

MEDICAL If selected, choose a plan below.	DENTAL Washington Dental Service (WDS)	VISION Vision Service Plan (VSP)
<input type="checkbox"/> For myself only.	<input type="checkbox"/> For myself only.	<input type="checkbox"/> For myself only.
<input type="checkbox"/> For myself & my spouse*.	<input type="checkbox"/> For myself & my spouse*.	<input type="checkbox"/> For myself & my spouse*.
<input type="checkbox"/> For myself & my children.	<input type="checkbox"/> For myself & my children.	<input type="checkbox"/> For myself & my children.
<input type="checkbox"/> For myself, spouse* & children.	<input type="checkbox"/> For myself, spouse* & children.	<input type="checkbox"/> For myself, spouse* & children.
<input type="checkbox"/> I DECLINE THIS COVERAGE.	<input type="checkbox"/> I DECLINE THIS COVERAGE.	<input type="checkbox"/> I DECLINE THIS COVERAGE.



MEDICAL PLANS – If you selected to enroll in WCIF medical coverage, please choose your plan below.

PLAN	REQUIREMENTS
<input type="checkbox"/> Transamerica Medicare Supplement Program	<ol style="list-style-type: none"> 1. Must be age 65 or over 2. Must be enrolled in Medicare Parts A and B 3. Must complete additional enrollment forms (see Transamerica Medicare Supplement Program Packet for additional forms)
<input type="checkbox"/> Group Health WCIF 750 Plan	<ol style="list-style-type: none"> 1. Must be age 64 or under 2. Must be enrolled in a WCIF Group Health plan as an active employee.
<input type="checkbox"/> Premera WCIF 750 PPO Plan	<ol style="list-style-type: none"> 1. Must be age 64 or under 2. Must be enrolled in a WCIF Premera PPO plan as an active employee.
<input type="checkbox"/> Premera 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 age 64 or under 3. Must be enrolled in a WCIF Premera PPO plan as an active employee.

* Or qualified domestic partner

SECTION IV: DEPENDENT ENROLLMENT

Enroll the following dependent(s):

- Spouse¹ | Marriage Date²:
- Child(ren) to Age 26
- Disabled Child(ren) Past Age 26

Dependents who are eligible for WCIF coverage include:

- A lawful spouse or 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.

DEPENDENT INFORMATION						ENROLL IN:		
						Medical	Dental*	Vision*
#1	Last Name:		First Name:		Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	SSN:	Date of Birth:	Relationship:	Same Address as Retiree? <input type="checkbox"/> Yes <input type="checkbox"/> No (if NO include below)				
#2	Last Name:		First Name:		Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	SSN:	Date of Birth:	Relationship:	Same Address as Retiree? <input type="checkbox"/> Yes <input type="checkbox"/> No (if NO include below)				

Retiree Name (first and last): _____

#3	Last Name:		First Name:		Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	SSN:	Date of Birth:	Relationship:	Same Address as Retiree? <input type="checkbox"/> Yes <input type="checkbox"/> No (if NO include below)				

DEPENDENT(S) – OTHER ADDRESS

If you checked **NO** under "Same Address as Retiree" for any of the above dependents, complete the following.

Address:		City:	State:	Zip:
Dependents under other address (as listed above): <input type="checkbox"/> #1 <input type="checkbox"/> #2 <input type="checkbox"/> #3				
If you have additional dependents and/or additional dependent addresses, you may include them on a separate sheet of paper.				

¹ Or qualified domestic partner | ² Or registration of domestic partnership

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

OTHER COVERAGE

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 have other medical coverage:

Self **Dependent(s) as listed above:** #1 #2 #3

Other Coverage:	Subscriber Name:	Subscriber's Birthdate:	Plan Phone Number:	Coverage End Date:
2 nd Prior Coverage:	Subscriber Name:	Subscriber's Birthdate:	Plan Phone Number:	Coverage End Date:

SECTION VII: 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: _____



Transamerica
(administered through
Benistar)
100 Grist Mill Rd
Simsbury, CT
06070
Plan number unique to
member.



Premera Blue Cross
7001 220th St SW
Mountlake Terrace, WA
98403
Plan number unique to
former employer.
Contact WCIF at
800.344.8570 to obtain.



GroupHealth

Group Health Options
Inc
320 Westlake Avenue N
Suite 100
Seattle, WA 98109-5233
0846600/6807600



Washington Dental
Service
9706 4th Ave NE
Seattle, WA 98115
00499



Underwritten and offered
by Vision Service Plan
600 University St, Ste
2004
Seattle, WA 98101
07103577

MAIL APPLICATION TO:

BENEFIT SOLUTIONS, INC. (BSI)
PO Box 6 • Mukilteo, Washington • 98275