



AWC Retiree Dental Insurance Enrollment Form

New Change Effective date: _____

Retiree Please print in blue or black ink.

| | | | |
|-------------------------------------|--------|----------------|--|
| Former employer | | SSN of insured | |
| Retiree name (last, first, initial) | Gender | Birth date | |
| Home address | | Home phone | |
| City | State | Zip | |

Dependents Please list all dependents to be covered. A dependent is the employee's spouse, or a child, stepchild or adopted child; less than age 26 or prior to age 26 was incapable of self-support due to developmental disabilities or physical handicap (proof of incapacity required).

| | Birth date (mo-day-yr) | <input checked="" type="checkbox"/> | Check if dependent is overage and disabled. Spouse: list date of marriage. | Date started school List name and year of school. |
|-----------|---------------------------|-------------------------------------|---|--|
| Spouse | | | | |
| Dependent | | | | |
| Dependent | | | | |
| Dependent | | | | |

C.O.B. (Coordination of benefits information)

Do you or any of your dependents have other dental coverage? Yes No If yes, complete the following section.

| | | |
|---|------------|-----|
| Name (last name, first name) | Birth date | SSN |
| Name and policy number of other insurance | | |
| Address of other insurance | | |
| Employer of insured | | |
| Insurance covers: <input type="checkbox"/> Insured only <input type="checkbox"/> Insured & spouse <input type="checkbox"/> Insured & dependents <input type="checkbox"/> Insured & children | | |

Your signature is required. Please sign on back.

Plan Enrolled On Please check the plan you are enrolling on.

 **DELTA DENTAL**
Washington Dental Service

Washington Dental Service is a member of the
Delta Dental Plans Association

Washington Dental Service

PPO Retiree Dental Plan



Willamette Dental

Retiree Dental Plan

Retiree Dental Insurance Enrollment Form *continued...*

Your Signature is Required Claims cannot be processed unless this form is signed and dated. Please note that failure to fully complete this enrollment form may result in this form being returned to you and will delay processing of the form.

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

I acknowledge and understand my health plan 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 health-care treatment, payment or for the purpose of business operations necessary to administer health-care 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 health care 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.

I verify that all of the information specified on this application is accurate and complete. I have also read and understood the application and the release of information provisions stated above.

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.

Signature _____ Date _____

Automatic Pension Deduction Authorization

Dept. of Retirement Systems (DRS)

Your Signature is Required to authorize automatic pension deduction

At my own risk, I request the Washington State Department of Retirement Systems (DRS) to deduct from my monthly pension plan allowance the amount reported to DRS by the Association of Washington Cities (AWC) Employee Benefit Trust to pay my monthly insurance premiums. I request that DRS pay that amount to the AWC Employee Benefit Trust, and authorize the AWC Employee Benefit Trust to change or discontinue such deduction.

I hereby agree to hold the Department of Retirement Systems and the AWC Employee Benefit Trust, their agents and employees, harmless from any liability for failure to properly or timely make the deductions or payments authorized by this document.

I hereby agree that any future requests to change my deduction or cancellations of coverage will not be valid unless submitted through the AWC Employee Benefit Trust.

Signature _____ Date _____

Retirement System/Plan Code: (check one)

PI = PERS 1

P2 = PERS 2

P3 = PERS 3

LI = LEOFF 1

L2 = LEOFF 2