

Spouse/Domestic Partner

Please list spouse/domestic partner who should be covered on your insurance. Leaving them off will terminate coverage. Proof of dependency may be requested, including, but not limited to, marriage certificate, affidavit of marriage/domestic partnership, divorce papers.

Spouse/domestic partner name (last, first, initial)

SSN

Gender

Date of birth

Home address

Home phone

City

State Zip

County

 Single Widow/widower Married Date married: Divorced Date divorced: Domestic partnership Date met DP criteria: Partnership termination Date terminated:**Primary Care Provider (PCP)** (Required for Group Health or Regence BlueShield Selections 1000 coverage only.) Group Health PCP name

City, State

 Selections PCP name

City, State

Medicare information

Medicare claim number

Date enrolled on Medicare Part A

Date enrolled on Medicare Part B

Is spouse/domestic partner covered by any other insurance now or in the past three months? Yes No

If yes, name of other medical insurance company

Group/policy #

Effective date

Termination date

***Subscriber signature is required
on the back of this form.***

Dependents

Please print in blue or black ink.

Proof of dependency may be requested including, but not limited to, birth certificate, marriage certificate, divorce papers, adoption papers. A dependent is a child, stepchild or adopted child up to age 26 or prior to age 26 was incapable of self-support due to developmental disabilities or physical handicap (proof of incapacity required).

Dependent # _____ Please check all appropriate boxes and fill in the appropriate blanks. For additional dependents, please fill out additional forms and alter "Dependent # _____."

Name (last, first, middle initial)

SSN

Gender

Date of birth

Relationship to insured

Are you providing total or partial support for him/her? Yes No

Primary Care Provider (PCP) (Required for Group Health or Regence BlueShield Selections 1000 coverage only.)

Group Health PCP name

City, State

Selections PCP name

City, State

Does he/she live with you? Yes No

If no, name of person with whom he/she resides.

SSN

Home phone

Home address

City

State Zip

If divorced, do you have custody? Yes No

If no, name of person with custody (last, first initial)

SSN

Home phone

Home address

City

State Zip

Is dependent covered by any other insurance now or in the past three months? Yes No

If yes, name of other medical insurance company

Name of insured


SSN of insured

Group/policy #

Effective Date

Termination date

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

 **Regence**
Regence BlueShield is an Independent Licensee
of the Blue Cross and Blue Shield Association
PO Box 21267
Seattle, WA 98111

- Regence BlueShield**
- AWC HealthFirst 1000™
- Selections 1000
- Plan R 1500

 **ASURIS**
NORTHWEST HEALTH
PO Box 91130
Seattle, WA 98111

- Asuris Northwest Health**
- AWC HealthFirst 1000™
- Plan R 1500

 **GroupHealth**
PO Box 34750
Seattle, WA 98124

- Group Health Cooperative**
- Group Health Retiree Plan

Your Signature is Required

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 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 for myself and my dependents listed on this form to the carrier (listed on back of this form) that covers me and my family members (if applicable). 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 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.

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 _____

Retiree: Send completed form to: **1076 Franklin Street S.E., Olympia, WA 98501-1346**

Automatic Pension Deduction 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 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 Association of Washington Cities 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, dependency status, or cancellations of coverage will not be valid unless submitted through the Association of Washington Cities 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