Administered by Welfare & Pension Administration Service, Inc.
P.O. Box 34203 • Seattle, WA 98124-1203
Phone (888) 563-0665 • Fax (206) 505-9727

Date of Hire	
Effective Date:	

SPOKANE FIRE FIGHTERS BENEFIT TRUST

Non-Medicare Eligible Retiree ENROLLMENT FORM

PLEASE PRINT

A COMPLETED ENROLLMENT FORM MUST BE ON FILE IN THE ADMINISTRATION OFFICE FOR YOU AND YOUR DEPENDENTS BEFORE ANY CLAIMS CAN BE PROCESSED. ***It is necessary to attach copies of your marriage certificate to enroll your spouse/registered domestic partner, and birth certificates for any children you wish to cover.*** **SEE PAGE 2 OF FORM FOR DEFINITION OF ELIGIBLE DEPENDENTS.**

☐ Open Enrollment ☐ New Member ☐ Add/Delete Dependent(s)
☐ Name Change:_____ ☐ Address Change ☐ Other _____ *(please specify)*
(Maiden Name)

RETIREE NAME (Last, First, Middle Initial)	SOCIAL SECURITY NUMBER	SEX	BIRTHDATE (Mo/Day/Year)

Marital Status
☐ Single ☐ Married ☐ Divorced ☐ Widowed

Date of Marriage/Divorce (Mo/Day/Year)

Mailing Address (Street or PO Box, City, State, Zip Code)

Phone Number

Email Address

Please Indicate Retiree Status:
☐ LEOFF I ☐ LEOFF II ☐ Other *(please specify):*

Please Indicate Spouse Status:
☐ Surviving Spouse ☐ Spouse of Medicare Entitled Retiree ☐ Spouse of a LEOFF I Member ☐ Other *(please specify):*

RETIREE PLANS – Premera Blue Cross

Please Choose One:	☐ **Classic $1,500**	☐ **Economy $2,500**	
☐ **Retiree Only**	☐ **Retiree & Child**	☐ **Retiree & Spouse & Child**	
☐ **Retiree & Spouse**	☐ **Retiree & Children**	☐ **Retiree & Spouse & Children**	

You are committed to your plan selection for the current Plan Year. You will have the opportunity to make a change during the next open enrollment period or if you have a Qualifying Change of Status (marriage, birth, divorce, etc.) or if you choose to move from the Lower Deductible Plan to the Higher Deductible Plan. I also confirm I am not ***eligible*** for any portion of Medicare coverage.

FAMILY MEMBER ENROLLMENT

NAME of Family Member (Last, First, Middle Initial)	SSN	SEX	BIRTHDATE (Mo/Day/Year)	RELATIONSHIP	☑ Add/Delete
					☐
					☐
					☐
					☐

Are you, your spouse/registered domestic partner, or other dependents covered by any other group medical, dental or vision plan, including Medicare?

☐ Yes ☐ No If "yes," please provide the information requested. If you or your dependent have Medicare, the person enrolled/eligible for Medicare is not eligible to enroll in this coverage.

Name of Subscriber with Other Coverage Social Security Number

Name of other Insurance Company Policy or I.D. Number

Address of other Insurance Company City State Zip

1. Insurance covers: ☐ Subscriber ☐ Spouse/Registered Domestic Partner ☐ Children
2. Coverage includes: ☐ Medical ☐ Dental ☐ Vision

Enrollment information that I previously submitted for a specific insurance plan is superseded by changes indicated on this form. By signing below, I acknowledge that I wish to enroll myself and my family members in the medical/dental plan coverage as indicted on the front of this form. I certify that the family members enrolled on this form meet the definition of Eligible Family Member, as stated below and incorporated into the "Summary Plan Description of the Spokane Fire Fighters Benefit Trust."

By signing below, I declare that the information on the Enrollment Form is true, correct, and complete to the best of my knowledge, and that I have read and understand the Enrollment Form and Enrollment Guide covering the options provided under the plan. 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. I authorize the Trust's insurance carriers and administrators to obtain, examine or release information needed to coordinate benefits or process claims for me or my family. I understand I may be subject to disciplinary action and/or repayment of any claims paid by my health plan, or contributions paid or remitted by the Spokane Fire Fighters Benefit Trust if I have provided false, incomplete, or misleading information, or fail to update this information in accordance with eligibility rules set by the Trust.

I hereby certify that the above information is true, correct, and complete to the best of my knowledge. **ATTACHED ARE TRUE COPIES OF OUR APPROPRIATE MARRIAGE CERTIFICATES, BIRTH CERTIFICATES, COURT-APPROVED ADOPTION OR LEGAL GUARDIANSHIP DOCUMENTATION.** The above information will be used to determine eligibility for claim/benefit purposes.

Member Signature	Member Name	Date

(must be signed by participating member)

Please return form to the Trust Office at:
Welfare & Pension Administration Service, Inc.
P.O. Box 34203 • Seattle, Washington 98124
Phone (888) 563-0665 • Fax (206) 505-9727
Or scan and email to: enrollment@wpas-inc.com

Please select your payment plan option below. Your signature above authorizes payment as outlined below, including any automatic deduction until such time as you notify the Spokane Fire Fighters Benefit Trust office in writing. I understand that my deduction may be automatically increased or decreased for any changes in premiums I am required to pay for coverage I selected. I hold DRS harmless for any problems on coverage or premium charges that occur between the insurance carrier and myself.

☐ DRS PENSION DEDUCTION $_____ ☐ RETIREE SSN: _____

☐AUTO WITHDRAWAL ☐ CHECKING_____ ☐ SAVINGS _____

☐ ACCOUNT NO:_____ ☐ ROUTING NO: _____

☐ SELF PAY (personal check) $ _____

NOTICE

Please be advised that this form MUST be signed by the participating Member for beneficiary designations to be valid.

ELIGIBLE RETIREE MEMBERS

You are eligible for the Retiree Plan if you are:

A retired fire fighter from the City of Spokane who was a dues paying member of Local 29 at the time of retirement, AND
Eligible to receive a pension from employment with the City of Spokane.
If you are not currently eligible and/or enrolled in Medicare, then you are not eligible for this coverage.

Eligible Spouse/Registered Domestic Partners:

Legal Spouse of a Retired LEOFF I or LEOFF II member, which includes the legally formed marriage of two persons validly formed in any jurisdiction in the United States or in a foreign jurisdiction that is recognized under Washington law,
Surviving spouse of a deceased member (not divorced) who was enrolled for active or retiree coverage at the time of death or is a surviving spouse of a LEOF 1 member who was enrolled for coverage in the Plan prior to the death of the LEOFF 1 member,
Domestic Partner registered pursuant to state law or domestic partners who have signed and meet all of the requirements of the affidavit of Domestic Partnership established by the Trust.
If you are not currently eligible and/or enrolled in Medicare, then you are not eligible for this new coverage.

Eligible Children:

Natural Children of the member or spouse,
Legally adopted children of the member or spouse,
Surviving children of deceased member,
Children of a registered Domestic Partner,
Child placed with the member and spouse for the purpose of legal adoption,
Foster children are <u>not</u> eligible.