RETIREE HEALTH CARE BENEFITS ELECTION FORM
NEW RETIREE ENROLLMENT

Last Name First Name SSN DOB

Home Address - Street City State Zip

Phone Number E-mail Retiree Number

Retiree Effective Month of Coverage Retirement Date

Retiree Under Age 65 Medical Plan Selection

- ☐ City of Seattle Preventive Plan: 100290-22-___-___-___
- ☐ City of Seattle Traditional Plan: 100290-12-___-___-___
- ☐ Kaiser Permanente Deductible Plan: ________________
- ☐ Kaiser Permanente Standard Plan: __________________

Enrollment Designation

- ☐ Retiree Only
- ☐ Retiree & Spouse/Domestic Partner
- ☐ Retiree, Spouse/Domestic Partner & One Child
- ☐ Retiree & Child
- ☐ Each Additional Child

Retiree Medicare Medical Plan Selection

☐ Medicare Plan Option (Age 65 and over). Must use plan specific enrollment packet and submit a copy of your Medicare Parts A and B card with the enrollment form. Contact Human Resources (206) 615-3328 to request for appropriate enrollment form.

Add Dependent Coverage Information: List all eligible dependents to be included. Attach list for any additional dependents.

Spouse/Domestic Partner

Last Name First Name MI SSN DOB

- ☐ City of Seattle Preventive Plan
- ☐ City of Seattle Traditional Plan
- ☐ Kaiser Permanente Deductible Plan
- ☐ Kaiser Permanente Standard Plan
- ☐ Medicare Plan Option (65 and over)

Relationship

☐ **Spouse**
☐ Male ☐ Female

OR

☐ **Domestic Partner**
☐ Male ☐ Female

Dependent Child

Last Name	First Name	MI	SSN	DOB	☐ City of Seattle Preventive Plan ☐ City of Seattle Traditional Plan ☐ Kaiser Permanente Deductible Plan ☐ Kaiser Permanente Standard Plan

Relationship

Retiree's Dependent	**OR**	**Partner's Dependent**	**Disabled?**
☐ Son ☐ Daughter		☐ Son ☐ Daughter	☐ Yes ☐ No

Dependent Child

Last Name	First Name	MI	SSN	DOB	☐ City of Seattle Preventive Plan ☐ City of Seattle Traditional Plan ☐ Kaiser Permanente Deductible Plan ☐ Kaiser Permanente Standard Plan

Relationship

Retiree's Dependent	**OR**	**Partner's Dependent**	**Disabled?**
☐ Son ☐ Daughter		☐ Son ☐ Daughter	☐ Yes ☐ No

☐ **I ACCEPT COVERAGE**

Previously submitted enrollment information for a specific insurance plan is superseded by changes indicated on this form. I certify that my family members and I are eligible for the coverage requested. I authorize Seattle Housing Authority to deduct from my pension any premium I am required to pay for the coverage I selected above.

By signing below, I declare that the information on this form is true, correct and complete to the best of my knowledge; that I have read and understand the election form and descriptive material covering the options provided under the City of Seattle's benefit plans. I authorize the insurance carriers to obtain, examine or release information needed to coordinate benefits or process claims for myself or my family. I understand I may be subject to disciplinary action and/or repayment of any claims paid by my health plan or premiums paid by my employer if I have provided false, incomplete, or misleading information, or fail to update this information in accordance with eligibility guidelines.

________________________________ Retiree's signature

________________________________ Date

☐ **I DECLINE COVERAGE**

If you have other employer sponsored group medical coverage and involuntarily lose that coverage, you may enroll within 30 days of the loss of the other coverage upon providing proof of continuous medical coverage. If you leave the City sponsored medical plan and enroll on an individual plan, you will not be eligible to re-enroll in a City sponsored plan.

If you decline coverage and are not enrolled in another employer sponsored group medical insurance elsewhere, you will NOT be eligible to enroll in a City of Seattle sponsored medical plan.

________________________________ Retiree's signature

________________________________ Date

SHA Human Resources Department________________________ Date Received _______________