Healthcare Benefits
Snohomish County – Central Human Resources

HR USE ONLY	
Effective Date	
End Date (If known)	

Regence Retiree Medical Plan Enrollment/Change Form

Retiree Information

Last Name	First Name	M.I.	Gender

Social Security #	Date of Birth	Marital Status	Home Phone

Home Mailing Address ☐ New Address	City	State	Zip

Reason For Enrollment/Change

☐ New Enrollment ☐ Removing Coverage ☐ Other Reason (Specify): _____ Date of Other Reason: _____

Medical Insurance Plan

☐ Regence Retiree $250 PPO Plan A; #10008695 – Regular Retirees Only

☐ Regence Retiree $250 PPO Plan B; #10008695 – LEOFF 1 Retirees Only

Family Information

List all dependents below. Attach documentation (ex. marriage/birth certificate) to this form if adding a dependent *not* currently active on Regular Employee Medical Coverage.

1	Last Name	First Name	M.I.	Relationship	**Medical** ☐ Enroll ☐ Remove
	Social Security	Date of Birth		Gender	
2	Last Name	First Name	M.I.	Relationship	**Medical** ☐ Enroll ☐ Remove
	Social Security	Date of Birth		Gender	

Regence - Consent to Electronic Distribution

Regence has established a process under which communications to members can be posted to secured account that a member establishes on Regence.com, with e-mail notice provided to a member-supplied e-mail account when a new communication is posted. By contesting to receive electronic distribution by marking the checkbox below, I consent, on behalf of myself and any covered dependents, to the electronic distribution of communications related to the coverage applied for and understand that: To access electronically distributed communications, I and each of my covered dependents will need to establish Regence.com accounts for use on a system meeting the outlined requirements and I represent that we each have and will continue to have access to such a system or systems. Not all member communications are currently available electronically, but agree that my consent will apply to the following materials available, or as they become available, for electronic distribution, (i) notices of enrollment and/or effective date, (ii) acknowledgements of receipt of claims, requests for additional information related to claims and notices of associated delays in processing, and determinations on submitted claims, (iii) general informational disclosures required by law, including but not limited to notices of rights under the Women's Health and Cancer Rights Act, state patient protection acts, and privacy laws, (iv) communications regarding complaints, grievances, or appeals, including but not limited to acknowledgements of receipt, requests for additional information and notices of associated delays, and notices of determinations, (v) summaries of benefits and coverage and uniform glossary of terms, (vi) notices of benefit changes or policy modifications, (vii) renewal information, (viii) notices of discontinuation, (ix) notices of termination and continuation coverage rights, (x) certificates of creditable coverage, (xi) billing notices and statements. Until a type of communication can be distributed electronically, a paper copy will be provided. Once available in electronic form, any electronically distributed communications may be printed from the Regence.com account where they are posted, or a paper copy of any particular communication may be requested at any time using Regence.com or by contacting Regence Customer Service at the number provided on my ID card. I may change the e-mail address for receipt of notice of electronic distributions or withdraw consent at any time and without charge using Regence.com or by contacting Regence.

☐ I consent to receive electronic distribution. My personal e-mail address is *(Print clearly):* _____

☐ I do not consent to receive electronic distribution, and I elect to receive all communications in paper format.

Authorization & Signature

I have read the information and acknowledge that the sections above represent my enrollment choices. 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. I understand that I am solely responsible for any required premium payments due for my enrollment choices, whether self-paid or paid through pension deductions. I understand that my preferred payment method should be communicated to Snohomish County Human Resources prior to this enrollment as additional forms or authorization may be required. Lastly, I understand that if I un-enroll in this healthcare coverage at a later date, it will be my responsibility to have other coverage in place as I will not eligible to re-enroll in this coverage on a later date.

Last Name	First Name

Signature	Date