IAFF LOCAL 726
Administered by Vimly Benefit Solutions, Inc.
P.O. Box 6, Mukilteo, WA 98275
***P:** (866) 265-5231 | **F:** (866) 676-1530 | **E:** IAFFHealthTrust@vimly.com*

LOCAL 726 HEALTH & WELFARE TRUST
2026 MEDICARE-SUPPLEMENT ENROLLMENT FORM - SPOUSE

Please Print Clearly

Reason for Submission:
☐ Open Enrollment ☐ Medicare-Eligible ☐ Address Change ☐ Name Change ☐ Other: _____

Status: ☐ Surviving Spouse ☐ Spouse of Medicare-Eligible Retiree ☐ Spouse of LEOFF 1 Retiree ☐ Spouse of Non-Medicare-Eligible Retiree
Name of Retired Fire Fighter: _____

Coverage Effective Date:	**Medicare ID #:**

Employer Group Retired From: ☐ Central Pierce F&R
☐ Graham F&R ☐ CPFR Mechanics ☐ CPFR Chiefs ☐ CPFR Deputy Chiefs ☐ CPFR IT ☐ South Pierce F&R

PERSONAL INFORMATION

First Name:	Middle Name:	Last Name:	
Street Address:			SSN:
City:	State:	Zip:	Date of Birth:
Marital Status:	Date of Marriage/Divorce:		Gender: ☐ M ☐ F
Home Phone:	Cell Phone:	Email:	

RETIREE MEDICAL PLANS FOR MEDICARE-ELIGIBLE – Labor First

Choose one of the following:

Standalone Medicare Supplement
No Prescription Coverage included with this option
☐ TransAmerica Plan F Medicare Supplement

Medicare Advantage (MAPD) Plans
Includes Medical and Prescription Drug Coverage
☐ Humana High Option ☐ Humana Low Option

DENTAL PLAN – WCIF *(Choose One)*
One-time election for new retirees only

☐ **Delta Dental Retiree Plan** ☐ **Willamette Dental Retiree Plan**

COORDINATION OF BENEFITS: If you currently have other group medical or dental coverage (including Medicare), please complete below.

Medical	Subscriber Name	Insurance Provider	Effective Date	Termination Date	Medicare (List A, B or Both)	Plan Number or Medicare HIC #
☐						
☐						

PLEASE NOTE: This enrollment form is not valid until it is signed and dated on the reverse side.

IAFF LOCAL 726
Administered by Vimly Benefit Solutions, Inc.
P.O. Box 6, Mukilteo, WA 98275
***P:** (866) 265-5231 | **F:** (866) 676-1530 | **E:** IAFFHealthTrust@vimly.com*

Enrollment information that I previously submitted for a specific insurance plan is superseded by changes indicated on this form.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 in the medical/dental plan coverage as indicated on the front of this form. I certify that I meet the definition of an Eligible Person as defined in the Plan Certificate of Coverage and incorporated into the "Enrollment Guide of the IAFF Health & Wellness Trust".

By signing below, I declare that the information on the Enrollment Application is true, correct, and complete to the best of my knowledge, and that I have read and understand the Enrollment Application and Enrollment Guide covering the options provided under the plan. 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 that it is a crime to knowingly provide false, incomplete, or misleading information to an insurance company. Penalties include imprisonment, fines and denial of insurance benefits.

_____ _____
Spouse Signature Date

_____
Print Name

Please select your payment option below.

***If selecting DRS or Debit for the first time,** please complete the associated authorization form and submit it along with your enrollment form and a check for your first month's premiums.*

☐ DRS $_____ ☐ DRS Authorization Form Attached ☐ On File

I authorize the Department of Retirement Systems (DRS) to regularly deduct a sufficient amount from my retirement benefit to pay the premiums for my insurance coverage. I will not hold DRS responsible for any problems on coverage or premium charges that occur between the insurance carrier and myself. The deductions will continue until I write to the insurance company and DRS asking for my deductions to stop or I terminate the insurance plan. I understand that DRS cannot answer questions about my insurance.

☐ DEBIT $_____ ☐ ACH Authorization Form Attached ☐ On File

☐ Bill Retiree Premium to Employer (LEOFF 1's only) & Bill Dependent Premiums to Retiree*
**Please select spouse premium payment selection from one of the options above*

Please return form to the Trust Office at:
Vimly Benefit Solutions
P.O. Box 6, Mukilteo, WA 98275
Ph: (866) 265-5231 **Fax:** (866) 676-1530 **Email:** IAFFHealthTrust@vimly.com

IAFF LOCAL 726
Administered by Vimly Benefit Solutions, Inc.
P.O. Box 6, Mukilteo, WA 98275
***P:** (866) 265-5231 | **F:** (866) 676-1530 | **E:** IAFFHealthTrust@vimly.com*

PLEASE READ THIS IMPORTANT INFORMATION IF YOU ARE ENROLLING IN A HUMANA PLAN

I understand that if I am receiving assistance from a sales agent, broker, or other individual employed by or contracted with Humana, he/she may be paid based on my enrollment in Humana.

If you qualify for extra help with your Medicare prescription drug coverage costs, Medicare will pay for all or part of your plan premium. If Medicare pays only a portion of this premium, we will bill you for the amount that Medicare doesn't cover.

By completing this enrollment application, I agree to the following:

The Humana Group Medicare PDP is a Medicare drug plan that has a contract with the Federal government and is in addition to my coverage under Medicare; therefore, I will need to keep my Medicare coverage. It is my responsibility to inform Humana of any prescription drug coverage that I have or may get in the future. I understand that if I don't have Medicare prescription drug coverage, or creditable prescription drug coverage (as good as Medicare's), I may have to pay a late enrollment penalty if I enroll in Medicare prescription drug coverage in the future. I can only be in one Medicare prescription drug plan at a time and if I am currently in a Medicare prescription drug plan, my enrollment in Humana Group Medicare PDP will end that enrollment. Enrollment in this plan is generally for the entire year. Once I've enrolled in this Humana plan, I can change or cancel my Humana coverage at any time and return to Original Medicare or another Medicare Advantage plan using a special election. However, I may not be eligible to return to the group plan or change plans outside of the group's open enrollment period. I can receive details of my options by calling my plan administrator or customer service.

This Humana plan serves a specific service area. If I move out of the area that this Humana plan serves, I need to notify the plan so I can disenroll and find a new plan in my new area. Once I am a member of Humana, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage from Humana when I get it to know which rules I must follow in order to get coverage with this Medicare drug plan. I understand that I must use network pharmacies to access Humana benefits, except under limited, non-routine circumstances when I cannot reasonably use Humana network pharmacies.

I understand that I am enrolling into a Humana Medicare Advantage Plan or a Humana Medicare Prescription Drug Plan and not a Medicare Supplement, Medigap, Medicare Select, or Medicaid plan.

The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.

Release of Information:

By joining this Medicare prescription drug plan, I acknowledge that Humana will release my information to Medicare and other plans as necessary for treatment, payment and health care operations. I also acknowledge that Humana will release my information (including my prescription drug event data) to Medicare, who may release it for research and other purposes which follow all applicable Federal statutes and regulations.

If you are assessed a Part D-Income Related Monthly Adjustment Amount (Part D-IRMAA), you will be notified by the Social Security Administration. You will be responsible for paying this extra amount in addition to your plan premium. You will either have the amount withheld from your Social Security benefit check or be billed directly by Medicare or the RRB. DO NOT pay Humana the Part D-IRMAA.