Health Insurance Enrollment/Change Form for Retirees/Survivors

RETIREE INFORMATION		
PLEASE PRINT		
Retiree's Name	Civilian/Police/Fire	Employee ID #
Email address - Personal	Date Of Birth	Phone
Address	City/State/Zip	Effective Date

Medicare Information	Group Health Plan	Group Health Coverage
Complete if participant has Medicare Enroll in Advantage plan effective: _____ / 01 / _____	☐ Citicare Value ☐ Citicare Choice ☐ Draft A/R attached	☐ None/Terminate Coverage Notes:
Retiree# ☐ Part A ☐ Part B Spouse # _____ ☐ Part A ☐ Part B	☐ Citicare Fire Assn Pays_____ ☐ Draft A/R attached	☐ Retiree Only ☐ Retiree + Spouse ☐ Retiree + Children ☐ Retiree + Family
Retiree: Eff:_____ Spouse : Eff:_____ ☐ Local Advantage Plan ☐ Regional Advantage Plan	☐ Citicare Public Safety ☐ HLPS Form attached ☐ Draft A/R attached	Retiree Death or Medicare Advantage Date: _____ ☐ Retiree's Children Only ☐ Retiree's Spouse Only

DEPENDENT INFORMATION

Dependent Information Last, First MI	Date of Birth	SSN	Gender	Relation	Add/Drop

ACKNOWLEDGEMENT

I understand that I will be billed monthly for the premium to keep coverage in force. Failure to make timely payment will result in termination of coverage.
I understand that if I elect to cancel coverage for me and/or my dependents, I may not elect to enroll in the City's retiree health care plan in the future.

_____ _____

Signature **Date**

Office Use Only:

☐ RP ☐ RT ☐ RB

INFOR Entry Date: _____ **INFOR Entry Initials: _____**