

2017 RETIREE ENROLLMENT/CHANGE FORM



Please retain a copy for your records.

Complete the information below to enroll in the following 2017 benefit plans: Retiree Dental, Retiree Vision, and Under Age 65 Retiree Medical & Pharmacy. Failure to return this form within the appropriate timeframe could result in loss of coverage for you and your dependents. All retirees and dependents must provide a Social Security Number to enroll. Retirees and/or dependents enrolling in a City plan AND who are eligible for Medicare must complete the Medicare Section and provide a copy of your Medicare Card. Rates and plan details are in the 2017 Retiree Benefit Guide. Enrollment in Age 65+ Retiree insurance plans will be administered by United Healthcare Medicare Solutions Connector Model.

Effective Date: _____

RETIREE/SURVIVING SPOUSE INFORMATION

Last Name:	First Name:	Middle Initial:	Check one: <input type="checkbox"/> Retiree <input type="checkbox"/> Surviving Spouse
If Surviving Spouse, enter name of City Retiree:			
Mailing Address:		Social Security Number:	
City/State/ZIP code:		Date of Birth:	
Address Change? <input type="checkbox"/> Yes <input type="checkbox"/> No	Email Address:	Home/Cell Number:	

RETIREE ELIGIBILITY

Retirees and eligible dependents will only be permitted to enroll in retiree insurance offered through the City if the retiree is **not** eligible for group health coverage through another employer. To enroll yourself (and, if applicable, your dependents) in retiree insurance through the City, you must confirm that you are not eligible for group health coverage through your current employer. Retirees eligible for other coverage must complete the Waiver section on the back of this form.

I am **not** eligible for group health coverage through a current employer.*

*Note-If at any time you become eligible for group employer health coverage, you must contact the City of Arlington.

DEPENDENT INFORMATION (Complete for dependents you wish to enroll in benefits)

Name – PLEASE PRINT (Last, First, Middle Initial)	Relationship:	Gender:	Date of Birth: MM/DD/YYYY	Social Security No.: ###-##-####	Coverage Elected:
Spouse:	<input type="checkbox"/> Legal Spouse	<input type="checkbox"/> Male <input type="checkbox"/> Female			<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision
Child:	<input type="checkbox"/> Child <input type="checkbox"/> Stepchild <input type="checkbox"/> Other	<input type="checkbox"/> Male <input type="checkbox"/> Female			<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision
Child:	<input type="checkbox"/> Child <input type="checkbox"/> Stepchild <input type="checkbox"/> Other	<input type="checkbox"/> Male <input type="checkbox"/> Female			<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision

IMPORTANT: Documentation is required when adding coverage. Refer to the Retiree Benefit Guide for details.

MEDICARE INFORMATION – Must provide a copy of Medicare card to Human Resources

Name – PLEASE PRINT (Last, First, Middle Initial)	Relationship:	Eligible Date:	Effective Date:	Medicare Number:	Part A:	Part B:	Part D:
					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

FOR OFFICE USE ONLY:

LAWSON #:	MEDICAL:	CONTACT INFO UPDATED:
RETIREMENT DATE:	DENTAL:	DOCUMENTATION:
EFFECTIVE DATE:	VISION:	FINANCE:
LAWSON UPDATED:	PAYMENT METHOD:	YOS:

UNDER AGE 65 UNITED HEALTHCARE MEDICAL & PHARMACY PLANS

Select plan:	Select coverage level:	
<input type="checkbox"/> HDHP (High Deductible Health Plan) <input type="checkbox"/> EPO (Exclusive Provider Plan) <input type="checkbox"/> I decline MEDICAL coverage for: <input type="checkbox"/> Myself <input type="checkbox"/> My spouse <input type="checkbox"/> My dependent children Due to: <input type="checkbox"/> existence of other coverage <input type="checkbox"/> don't want/need	<input type="checkbox"/> Retiree only <input type="checkbox"/> Surviving Spouse only <input type="checkbox"/> Retiree & Spouse <input type="checkbox"/> Retiree & Family <input type="checkbox"/> Retiree & Child(ren) <input type="checkbox"/> Spouse only (Retiree is age 65 or older) <input type="checkbox"/> Spouse or Surviving Spouse + Child(ren)	Enter monthly cost: \$ _____ NOTE: Refer to 2017 Monthly Rate Chart at www.arlingtontx.gov .

DELTA DENTAL PLANS

Indicate which plan you are selecting.		Indicate the coverage level you will need for that plan.	
Select plan:	Select coverage level:		
Plan Name:	Retiree only (no dependents)	Retiree + 1 dependent:	Retiree + 2 or more dependents:
<input type="checkbox"/> DHMO (DeltaCare)	<input type="checkbox"/> \$10.92	<input type="checkbox"/> \$22.03	<input type="checkbox"/> \$33.06
<input type="checkbox"/> PPO Low	<input type="checkbox"/> \$14.70	<input type="checkbox"/> \$29.14	<input type="checkbox"/> \$51.29
<input type="checkbox"/> PPO High	<input type="checkbox"/> \$35.48	<input type="checkbox"/> \$70.24	<input type="checkbox"/> \$123.61
<input type="checkbox"/> I decline DENTAL coverage for: <input type="checkbox"/> Myself <input type="checkbox"/> My spouse <input type="checkbox"/> My dependent children			Enter monthly cost: \$ _____

SUPERIOR VISION PLAN

Select coverage level:	
<input type="checkbox"/> Retiree only (no dependents)	\$4.32
<input type="checkbox"/> Retiree + 1 dependent	\$8.98
<input type="checkbox"/> Retiree + 2 or more dependents	\$13.70
<input type="checkbox"/> I decline VISION coverage for: <input type="checkbox"/> Myself <input type="checkbox"/> My spouse <input type="checkbox"/> My dependent children	
Enter monthly cost: \$ _____	

MONTHLY COST – Payable to the City of Arlington

Enter the monthly cost of each plan you have selected:

\$ _____	+	\$ _____	+	\$ _____	=	\$ _____
<i>Under Age 65 Medical</i>		<i>Dental</i>		<i>Vision</i>		<i>Total Monthly Cost</i>

MAILING ADDRESSES

Mail your Enrollment/Change Form to: City of Arlington Benefits - MS 63-0790 PO Box 90231 Arlington, TX 76004-3231	Mail your monthly payments to: City of Arlington Finance Dept. - MS 63-0820 PO Box 90231 Arlington, TX 76004-3231
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WAIVER

I understand that as a Retiree, if I waive coverage because of other health, dental, or vision coverage, I may in the future be able to enroll myself and my eligible dependents, provided that I request enrollment within 30 days after such coverage ends.

I decline to enroll MYSELF in retiree insurance (___Health ___Dental ___Vision) due to being eligible for employer-based coverage.*
 I decline to enroll my SPOUSE in retiree insurance (___Health ___Dental ___Vision) due to being eligible for employer-based coverage.*
 I decline to enroll my CHILDREN in retiree insurance (___Health ___Dental ___Vision) due to being eligible for employer-based coverage.*

***NOTE: Waiver of coverage for any other reason is a permanent waiver and you will not be permitted to re-enroll in the City's retiree insurance plans.**

Signature _____ Date _____

SIGNATURES

My signature below affirms that my benefit enrollment includes only those dependents that meet the City of Arlington eligibility guidelines and that all information provided above is true and correct. I understand that any intentional false statement in my enrollment or willful misrepresentation relative thereto may be subject to financial restitution and/or cancellation of all coverage.

Retiree	Date	Human Resources	Date
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