

**Group Medical and Dental Plan**

\_\_New Enrollment, \_\_Open Enrollment, \_\_Change, \_\_Reinstate

Office Use Only

Classification: **RETIREE**

Effective Date of Coverage: \_\_\_\_/\_\_\_\_/\_\_\_\_ Medical Code: \_\_\_\_\_ Dental Code: \_\_\_\_\_

**Subscriber Information**

Retiree Last Name	First Name	M.I.	Social Security Number*	Date of Birth	Gender __M __F
Mailing Address		Apt	City	State	Zip
Retirement Plan (circle): Police, Fire, Employee's Retirement Fund			Job Class (circle): Management, Executive, Confidential, Fire, General, Police, Professional, Supervisory or Other: _____		
Last Department/Division	Date of Retirement	Home Phone ( ) _____-_____	e-mail address		

**If this is a Change, Indicate Type:** \_\_Add Dependent(s), \_\_Cancel Dependent(s), \_\_Cancel Retiree and Dependent(s), if any

(attach document for proof)

\_\_New address(as above), \_\_New Name: From \_\_\_\_\_ to \_\_\_\_\_

**This Change is due to:** \_\_Marriage \_\_Birth \_\_Medicare Eligibility \_\_Other: \_\_\_\_\_ Date of Event: \_\_\_\_\_

**Additional Information**

Have you had continuous health care coverage for the past 12 months? \_\_Yes \_\_No

If yes, please attach a copy of your certificate of coverage as evidence of prior coverage (required for new enrollees only).

Other than this Health Plan, will you and/or your family have other Health Insurance Coverage as of this date? Yes \_\_No Dental? \_\_Yes \_\_No

If yes, list Covered Person(s): \_\_\_\_\_ **Attach copy of ID Card(s)**

Insurance Company Name: \_\_\_\_\_ Do you or your spouse have Medicare? \_\_Yes \_\_No

Covered Individuals	Medical		Comprehensive Dental		Premium Dental	
	Indicate Option	Office use Only	Indicate Option	Office use Only	Indicate Option	Office use Only
Retiree Only	( )		( )		( )	
Retiree and One Dependent*	( )		( )		( )	
Retiree and Two or More Dependents*	( )		( )		( )	

\*Eligible dependents are: spouse or domestic partner and/or natural, adopted or awarded child as defined in the plan document.

**List below all eligible dependents you wish to cover on your medical or dental plan. Only dependents listed below will have coverage**

Last Name	First	M.I.	Date of Birth	Gender	Social Security Number*	Coverage Selections
(2) __Spouse or __Domestic Partner			MM-DD-YY	__M __F		__Add Medical __Drop Medical __Add Dental __Drop Dental
(3) Dependent			MM-DD-YY	__M __F		__Add Medical __Drop Medical __Add Dental __Drop Dental
(4) Dependent			MM-DD-YY	__M __F		__Add Medical __Drop Medical __Add Dental __Drop Dental
(5) Dependent			MM-DD-YY	__M __F		__Add Medical __Drop Medical __Add Dental __Drop Dental
(6) Dependent			MM-DD-YY	__M __F		__Add Medical __Drop Medical __Add Dental __Drop Dental

Proper documents required: marriage/domestic partner certificate, birth certificate, hospital birth record, adoption award, medical child support order.

**Authorization**

I hereby (1) **REQUEST** coverage for the Group Medical and/or Dental Plan for which I am, or may become eligible; (2) authorize the Pension Administrator to make the necessary deductions for the contributions, if any, required for the Health Plan. I hereby certify that the foregoing statements are true and correct to the best of my knowledge and I also authorize any hospital, physician or other persons who have attended me or examined me or my dependent(s) to disclose, when requested, any or all information with respect to any illness, injury, or medical history to the claims payor, utilization review company and/or case management company. A photostatic copy of this authorization shall be considered as effective and valid as the original. I understand that payments will be made directly to the hospital or physician for services rendered unless paid receipts are presented. \*The social security number of all covered individuals is required pursuant to Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007.

Retiree Signature \_\_\_\_\_ Date \_\_\_\_\_

**Declination - complete this section only if canceling your single coverage**

I hereby **DECLINE** \_\_Medical and/or \_\_Dental coverage. I realize that once I cancel my single medical and/or dental coverage, I may not elect the canceled coverage in the future. Coverage must be continued from the time of retirement and, if canceled, cannot be reinstated.

Retiree Signature \_\_\_\_\_ Date \_\_\_\_\_