HEALTH CARE INSURANCE FOR RETIREES

2014 OPEN ENROLLMENT PLAN ELECTION & ENROLLMENT FORM

— Please Print —

NAME: _____ **RETIREE ID NUMBER:** _____

DAYTIME PHONE: _____ **EMAIL ADDRESS:** _____

HEALTH PLAN ELECTIONS: Check the appropriate boxes in each column and section.

	CURRENT INSURANCE PLAN	EFFECTIVE JANUARY 1st CHANGE PLAN TO
MEDICAL Select ONE in Each Column	☐ Community Blue PPO ☐ Blue Cross Traditional ☐ Health Alliance Plan (HAP) HMO ☐ Opt Out / Waived Medical Coverage	☐ Community Blue PPO ☐ Health Alliance Plan (HAP) HMO ☐ Flexible Blue HDHP ☐ Opt Out / Waive Medical Coverage
DENTAL Select ONE in Each Column	☐ Golden Dental Plan HMO ☐ Midwestern Dental HMO ☐ Dencap Dental HMO ☐ DeltaCare USA Dental HMO ☐ No Dental Coverage	☐ Golden Dental Plan HMO ☐ Midwestern Dental HMO ☐ Dencap Dental HMO ☐ DeltaCare USA Dental HMO ☐ Waive Dental Coverage
VISION	Select ONLY if you want to supplement your current retiree optical reimbursement benefit.	☐ Heritage Vision Plan ** Election of this benefit will NOT replace your current optical plan.*

**** IMPORTANT:*** *Retiree Dental and Vision plan options are voluntary / supplemental benefits subject to monthly premiums paid by the retiree. The employer is not responsible for any cost associated with election of a supplemental benefit by the retiree.*

DEPENDENTS TO BE COVERED: List all individuals to be covered under the plan(s) selected. If any dependent listed is being enrolled for the first time, you MUST provide proof of eligibility (ex., marriage cert. for a spouse, birth cert. for a child). No dependent will be enrolled until verification is provided. Anyone not listed below that is currently enrolled will be removed from coverage effective January 1, 2014 and will be provided with COBRA health care continuation information.

LAST NAME	FIRST NAME	SEX (M/F)	DATE OF BIRTH	SSN	RELATIONSHIP TO RETIREE	ENROLLED IN MEDICARE? (Y/N)	OTHER GROUP HEALTH PLAN? (Y/N)

I understand that the changes that I have requested will be effective January 1, 2014 of this year. I further understand that if the plan elections I make require a monthly contribution towards the cost of the plan I hereby authorize a pension payroll deduction to commence in the appropriate amount beginning with my January pension check.

Office Use Only (CC)

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Signature *Date*