



2021 Retiree Benefits Enrollment / Change Form

As a retiree eligible for benefits, you may enroll in the City’s medical insurance and you are eligible to receive a \$2,000 life insurance benefit, payable to your beneficiary(ies) upon your death. If you do not wish to enroll in a benefit, select “Decline” for that benefit.

Failure to properly complete all necessary sections of the Enrollment form may lead to delays in processing, inability to enroll or large collections payments for benefits.

Please be prepared to provide the following information for your enrollment:

- Your Social Security Number
- Your dependents’ Social Security Numbers
- Proof of eligibility for your dependents, which may include one of the following:
 - copy of marriage certificate
 - most recent Federal Tax Return with spouse’s signature
 - most recent Federal Tax Return with dependent child(ren) listed
 - certified copy of birth certificate
 - legal documentation establishing custody, guardianship or foster care
- **IF MAKING A QUALIFYING LIFE EVENT CHANGE**, provide proof of your life event dated within 30 days of the change date.

The Wellness rate only applies to employees who participate in the City’s wellness program and complete all requirements of the program. Information on program requirements can be found in your benefits guide or on the Employee Center Website.

Coverage Level	Basic	Basic (Wellness)	Basic Plus	Basic Plus (Wellness)	COBRA Dental Coverage*
Retiree Only	\$290	\$240	\$422	\$372	\$26.52
Retiree /Child	\$660	\$610	\$996	\$946	\$79.56 for one or multiple dependents
Retiree /Spouse	\$824	\$774	\$1,159	\$1,109	
Retiree /Children	\$1,210	\$1,160	\$1,644	\$1,594	
Retiree /Family	\$1,402	\$1,352	\$1,935	\$1,885	
Spouse Only	\$591		\$739		
Spouse/Child	\$963		\$1,298		
Spouse/Children	\$1,511		\$1,959		

*COBRA Dental coverage is only available to those retirees who elected the coverage within 60 days of retirement. If elected, COBRA Dental coverage is effective for 18 months from the retirement date.

** The Wellness rate does not apply to the Spouse Only, Spouse/Child, or Spouse/Children coverage levels.



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Retiree Information

Name:		Social Security No.:	Date of Birth:	Employee No.:
Address:			City, State:	Zip:
Employment Date:	Phone No.:	Email Address:		

Emergency Contact

Name:	Phone No.:	Relationship:
Name:	Phone No.:	Relationship:

Reason For Enrollment/Change

Add/Drop Dependent Coverage

<input type="checkbox"/> Annual Enrollment <input type="checkbox"/> Medicare Eligible <input type="checkbox"/> Loss of Other Group Coverage <input type="checkbox"/> Reenrollment/Reinstatement <input type="checkbox"/> Cancel Employee Coverage <input type="checkbox"/> Retirement <input type="checkbox"/> Beneficiary Change (Life Insurance Only) <input type="checkbox"/> Other _____	<input type="checkbox"/> Add Eligible Dependent(s) due to: <input type="checkbox"/> Marriage <input type="checkbox"/> Birth of child <input type="checkbox"/> Adoption/ Custody of Child <input type="checkbox"/> Loss of Other Coverage <input type="checkbox"/> Other: _____ Date of Change _____	<input type="checkbox"/> Drop Dependent(s) due to: <input type="checkbox"/> Divorce/Legal Separation <input type="checkbox"/> Loss of Eligibility <input type="checkbox"/> Medicare/Medicaid Eligible <input type="checkbox"/> Eligible for Other Coverage <input type="checkbox"/> Death <input type="checkbox"/> Other: _____
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Medical Insurance (Blue Cross Blue Shield of North Carolina)

Medical Plan: <input type="checkbox"/> Enroll in Basic <input type="checkbox"/> Enroll in Basic Plus <input type="checkbox"/> Decline <input type="checkbox"/> No Change	Wellness Program: <input type="checkbox"/> Enroll <input type="checkbox"/> Decline	Coverage Level (Retiree): <input type="checkbox"/> Retiree Only <input type="checkbox"/> Retiree/Spouse <input type="checkbox"/> Retiree/Child <input type="checkbox"/> Retiree/Children <input type="checkbox"/> Retiree/Family	Coverage Level (Retiree Spouse): <input type="checkbox"/> Spouse Only <input type="checkbox"/> Spouse/Child <input type="checkbox"/> Spouse/Children <small>*Not eligible for Wellness Program premium discount</small>
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Are you or your spouse currently eligible for Medicare? Yes No

COBRA Dental Insurance (Savers Admin)

COBRA Dental coverage is only available to those retirees who elected the coverage within 60 days of retirement.

Complete this section ONLY if you are currently enrolled in COBRA Dental

If you are currently enrolled and make no change, you will stay enrolled until your eligibility ends or you fail to pay monthly premiums.

Continue coverage Discontinue coverage

Eligible Dependent(s) Information

Dependent 1:	Date of Birth:	Social Security No.:
Address: (If different from retiree)	City, State:	Zip Code:
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Relationship:	Medical: <input type="checkbox"/> Enroll <input type="checkbox"/> Waive <input type="checkbox"/> Remove
Dependent 2:	Date of Birth:	Social Security No.:
Address: (If different from retiree)	City, State:	Zip Code:
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Relationship:	Medical: <input type="checkbox"/> Enroll <input type="checkbox"/> Waive <input type="checkbox"/> Remove

Eligible Dependent(s) Information (Continued)			
Dependent 3:		Date of Birth:	Social Security No.:
Address: (If different from retiree)		City, State:	Zip Code:
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Relationship:	Medical: <input type="checkbox"/> Enroll <input type="checkbox"/> Waive <input type="checkbox"/> Remove	
Dependent 4:		Date of Birth:	Social Security No.:
Address: (If different from retiree)		City, State:	Zip Code:
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Relationship:	Medical: <input type="checkbox"/> Enroll <input type="checkbox"/> Waive <input type="checkbox"/> Remove	
Beneficiary Designation (\$2,000 Life Insurance)			
<p>The life insurance is provided by the City, at no cost to you. You must declare your beneficiary(ies) below. Primary beneficiary refers to the person(s) to whom the benefit will be paid in the event of your death. You may elect multiple primary beneficiaries and assign each a percentage number of the benefit, but it must equal 100%. Contingent beneficiary refers to the person(s) to whom the benefit will be paid in the event of your death and death of your primary beneficiary. You may elect multiple contingent beneficiaries and assign each a percentage number of the benefit, but it must equal 100%.</p>			
Beneficiary 1:		Relationship:	Date of Birth:
Address, City, State, Zip:		Social Security No.:	
Address, City, State, Zip:		Phone No.:	
Beneficiary Type: <input type="checkbox"/> Primary _____% <input type="checkbox"/> Contingent _____%			
Beneficiary 2:		Relationship:	Date of Birth:
Address, City, State, Zip:		Social Security No.:	
Address, City, State, Zip:		Phone No.:	
Beneficiary Type: <input type="checkbox"/> Primary _____% <input type="checkbox"/> Contingent _____%			
Beneficiary 3:		Relationship:	Date of Birth:
Address, City, State, Zip:		Social Security No.:	
Address, City, State, Zip:		Phone No.:	
Beneficiary Type: <input type="checkbox"/> Primary _____% <input type="checkbox"/> Contingent _____%			
Beneficiary 4:		Relationship:	Date of Birth:
Address, City, State, Zip:		Social Security No.:	
Address, City, State, Zip:		Phone No.:	
Beneficiary Type: <input type="checkbox"/> Primary _____% <input type="checkbox"/> Contingent _____%			

By means of my signature below, I acknowledge that I must notify Human Resources within thirty (30) days of any event such as divorce or ineligibility due to age that causes my covered dependent(s) to no longer meet eligibility requirements. I understand I cannot make changes to my benefits without a qualifying life event. I confirm that the covered dependent(s) who will be enrolled in my medical plan meet the definition of eligible dependent(s) for coverage and I understand I will be required to submit supporting documentation of dependent's eligibility for coverage such as a birth certificate or marriage certificate.

Retiree Signature: _____

Date: _____