2019 Retiree Benefits Enrollment / Change Form

As retiree eligible for benefits, you may enroll in the City's medical insurance and you are eligible to receive a $2,000 life insurance, 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
  - 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.

** 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

☐ Annual Enrollment
☐ Medicare Eligible
☐ Loss of Other Group Coverage
☐ Reenrollment/Reinstatement
☐ Cancel Employee Coverage
☐ Retirement
☐ Other
____

Add/Drop Dependent Coverage

☐ Add Eligible Dependent(s) due to:
☐ Marriage
☐ Birth of child
☐ Adoption/ Custody of Child
☐ Loss of Other Coverage
☐ Other:
____

☐ Drop Dependent(s) due to:
☐ Divorce/Legal Separation
☐ Loss of Eligibility
☐ Medicare/Medicaid Eligible
☐ Eligible for Other Coverage
☐ Death
☐ Other:
____

Date of Change ___________________________

Medical Insurance (Blue Cross Blue Shield of North Carolina)

Medical Plan:	Wellness Program:	Coverage Level (Retiree):	Coverage Level (Retiree Spouse):
☐ Enroll in Basic	☐ Enroll	☐ Retiree Only	☐ Spouse Only
☐ Enroll in Basic Plus	☐ Decline	☐ Retiree/Spouse	☐ Spouse/Child
☐ Decline		☐ Retiree/Child	☐ Spouse/Children
☐ No Change		☐ Retiree/Children	
☐ Change		☐ Retiree/Family	

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 employee)	City, State:	Zip Code:
Gender: ☐ Male ☐ Female	Relationship:	Medical: ☐ Enroll ☐ Waive ☐ Remove

Dependent 2:	Date of Birth:	Social Security No.:
Address: (If different from employee)	City, State:	Zip Code:
Gender: ☐ Male ☐ Female	Relationship:	Medical: ☐ Enroll ☐ Waive ☐ Remove

Eligible Dependent(s) Information (Continued)		
Dependent 3:	Date of Birth:	Social Security No.:
Address: (If different from employee)	City, State:	Zip Code:
Gender: ☐ Male ☐ Female	Relationship:	Medical: ☐ Enroll ☐ Waive ☐ Remove
Dependent 4:	Date of Birth:	Social Security No.:
Address: (If different from employee)	City, State:	Zip Code:
Gender: ☐ Male ☐ Female	Relationship:	Medical: ☐ Enroll ☐ Waive ☐ Remove

Beneficiary Information (for $2,000 Life Insurance)

The life insurance is provided by the City, at no cost to you. You must select 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 primary beneficiaries and assign each a percentage number of the benefit, but it must equal 100%.

Beneficiary 1:	Relationship:	Date of Birth:	Social Security No.:
Address, City, State, Zip:			Phone No.:
Beneficiary Type: ☐ Primary ___________%	☐ Contingent ___________%		
Beneficiary 2:	Relationship:	Date of Birth:	Social Security No.:
Address, City, State, Zip:			Phone No.:
Beneficiary Type: ☐ Primary ___________%	☐ Contingent ___________%		
Beneficiary 3:	Relationship:	Date of Birth:	Social Security No.:
Address, City, State, Zip:			Phone No.:
Beneficiary Type: ☐ Primary ___________%	☐ Contingent ___________%		
Beneficiary 4:	Relationship:	Date of Birth:	Social Security No.:
Address, City, State, Zip:			Phone No.:
Beneficiary Type: ☐ Primary ___________%	☐ 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: ______________