HARRISHEALTH
EMPLOYEE BENEFITS

2025–2026 RETIREE HEALTHCARE ANNUAL ENROLLMENT CHANGE FORM

DO NOT SUBMIT THIS FORM IF YOU ARE NOT MAKING CHANGES TO YOUR 2025–2026 ENROLLMENT

Retiree Full Name:_____ EEID#/Social Security No: _____

DOB:_____ Marital Status: ___Married ___Single Gender: M/F

Retiree Address: _____ _____ _____ _____
Street City State Zip

Phone Number:_____ Personal Email:_____

HRA
Please mark your elections clearly with an "x"

	Retiree Only	Retiree + Spouse	Split Spouse	Retiree + Child(ren)	Split Child(ren)	Retiree + Family	Split Family	Waive
Health Reimbursement Arrangement (HRA) – Flexible Benefit Administrators								

If you are Pre-65 please confirm if you or your enrolled dependents are receiving a federal subsidy.

☐ Yes, I confirm that my enrolled dependents and/or myself are receiving a federal subsidy and elect to decline HRA funding at this time.

☐ No, neither I nor my enrolled dependents are receiving a federal subsidy at this time.

Dental
Please mark your elections clearly with an "x"

	Retiree Only	Retiree + Spouse	Retiree + Child(ren)	Retiree + Family	Waive
Cigna DPPO					
Cigna DHMO					

Vision
Please mark your elections clearly with an "x"

	Retiree Only	Retiree + Spouse	Retiree + Child(ren)	Retiree + Family	Waive
National Vision Administrators **Vision – Base Plan**					
National Vision Administrators **Vision – Buy Up Plan**					

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Enrolled Dependents
(Include dependent information if you are covering them on ANY plan. Documentation required to enroll any new dependents.)

Relationship	Dependent Name	Gender	DOB	Social Security Number
		M / F		
		M / F		
		M / F		
		M / F		
		M / F		
		M / F		

Notices

As a retiree, I am electing the coverage(s) listed above and authorize any applicable premiums to be deducted from my monthly pension payment. If self-payment is required, I understand that I must make special arrangements. Failure to pay premiums on time for medical, dental, or vision coverage will result in loss of benefits after a 30-day grace period. If coverage is lost, it cannot be reinstated.

I understand that once I enroll in the HRA plan—or choose to waive coverage—my election is final and cannot be changed. Re-enrollment in the Harris Health System Group Health Plan will not be allowed.

If I or any enrolled dependents become eligible for a federal subsidy, I understand I must opt out of HRA funding by contacting the Harris Health Employee Benefits Department.

I also understand that I must notify Harris Health within 31 days of a qualified family status change. My medical, dental, and vision elections must remain in place for the full plan year unless such a qualified change occurs.

I certify that all information provided is accurate to the best of my knowledge, and that any dependents I am enrolling meet the eligibility requirements as defined by Harris Health System.

Terms and Conditions

Your participation in Harris Health System's Health and Welfare plans is subject to the terms outlined in the official plan documents, insurance agreements, and applicable laws, all of which may be updated over time.

- Fraud Notice: Any person who knowingly submits false or misleading information in an application or claim may be committing insurance fraud.
- Misrepresentation: Providing false information may result in the immediate and permanent loss of Harris Health System benefits.

By signing below, I acknowledge and agree to all terms and conditions outlined in this document.

Retiree Signature: _____ Date: _____

If you are making enrollment changes for the 2025–2026 plan year, please return your completed signed form by email, fax, or mail using the enclosed return envelope with prepaid postage.

- **Email:** MyHR@harrishealth.org
- **Phone:** 713-566-MyHR
- **Fax:** 713-440-5575