2024/2025 Retiree Healthcare Annual Enrollment Change

DO NOT SUBMIT THIS FORM IF YOU ARE NOT MAKING CHANGES TO YOUR 2024/2025 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:_____

Medical
Please mark your elections clearly with an "x"

	Retiree Only	Retiree + Spouse	Retiree + Child(ren)	Retiree + Family	Waive
CIGNA KelseyCare					
CIGNA High Deductible					
CIGNA Low Deductible					

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 Account (HRA) – VIA Benefits								

Dental
Please mark your elections clearly with an "x"

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

Vision
Please mark your elections clearly with an "x"

	Retiree Only	Retiree + Spouse	Retiree + Child(ren)	Retiree + Family	Waive
Davis Vision					

HARRISHEALTH SYSTEM

My HR

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

Do you or your dependents have other medical coverage? If yes, contact CIGNA at 800.244.6224 and provide other coverage information.
As a retiree I request the coverage(s) listed above and I authorize deductions for these coverages from my monthly Pension payment, if applicable. Special arrangements must be made for self-pay premiums. Failure to timely pay the retiree portion of medical, dental, or vision plan premiums will result in loss of benefits coverage after a 30-day grace period. If coverage is lost, benefit eligible retiree coverage cannot be reinstated.

I understand that in order for a benefit eligible retiree or benefit eligible dependent age 65 or over to receive medical expense coverage under this plan, the benefit eligible retiree or benefit eligible dependent age 65 or over must be enrolled in both Part A and Part B of Medicare. Failure to timely enroll in either Medicare Part A or Part B, will result in no medical expenses being covered and the administrator may not be able to verify coverage.

I understand that my enrollment in the HRA plan, or if I waive a benefit plan, the election is irrevocable and will not be able to re-enroll in Harris Health Systems Group Health Plan.

I understand that it is my responsibility to notify Harris Health System within 31 days of a family status change. I understand that my medical, dental, and vision benefits plans require that my election remain unchanged for the entire year unless I have a qualified family status change. I hereby certify the above information to be true to the best of my knowledge and the dependents for whom I am requesting coverage are eligible as defined by the Harris Health System eligibility rules. TERMS & CONDITIONS: Your participation in the Harris Health System Health & Welfare plans and coverages is, in all events, subject to the terms and conditions of the actual plan documents, insurance agreements and applicable laws, any of which may be amended from time to time. Your attention is particularly directed to the following items: FRAUD: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing false or deceptive statements, may be guilty of insurance fraud. MISREPRESENTATION: Penalties may include immediate and permanent loss of Harris Health System benefits. By signing below, I acknowledge and agree to all of the terms and conditions outlined within this document.

Retiree Signature: _____ Date: _____

If you are making enrollment changes for the 2024/2025 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