HARRISHEALTH SYSTEM

RETIREE ANNUAL BENEFIT ENROLLMENT FORM

****Only complete this form if you are making an enrollment change****

All elections are effective March 1, 2022 through February 28, 2023

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

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

Employee Address:_____ _____ _____ _____
Street City State Zip

Phone Number:_____ Personal Email:_____

Medical – CIGNA Group Plan
Please mark your medical elections clearly with an "x"

	Employee Only	Employee + Spouse	Employee + Child(ren)	Employee + Family	Waive
CIGNA KelseyCare					
CIGNA High Deductible					
CIGNA Low Deductible					
Health Reimbursement Account (HRA) – VIA Benefits					
HRA Split Election (Check One for Retiree and One for Dependent(s))	HRA Split Election KelseyCare High Deductible Low Deductible	HRA Split Election KelseyCare High Deductible Low Deductible	HRA Split Election KelseyCare High Deductible Low Deductible	HRA Split Election KelseyCare High Deductible Low Deductible	

Dental - MetLife
Please mark your elections clearly with an "x"

	Employee Only	Employee + Spouse	Employee + Child(ren)	Employee + Family	Waive
DPPO					
DHMO					

Vision – Davis Vision
Please mark your elections clearly with an "x"

	Employee Only	Employee + Spouse	Employee + Child(ren)	Employee + Family	Waive
Vision					

HARRISHEALTH SYSTEM

RETIREE ANNUAL BENEFIT ENROLLMENT FORM

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		

SECTION IV: OTHER HEALTHCARE COVERAGE

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 and applicable COBRA provisions would apply.

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 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: _____

Please return your completed, signed form by email, fax or by mail using the enclosed return envelope with prepaid postage.

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