DO NOT COMPLETE IF YOU ARE NOT MAKING PLAN CHANGES

RETIREE BENEFIT ENROLLMENT / CHANGE FORM

(PLEASE UPDATE ALL OF YOUR PERSONAL INFORMATION)

2019 ANNUAL ENROLLMENT

HARRISHEALTH SYSTEM

SECTION I: RETIREE PERSONAL INFORMATION

Retiree Name: Last, First, M.I.			Social Security No.		Employee ID	FOR OFFICE USE
						Date Form Received:
Hire Date	Marital Status	Gender	Birth Date	Personal Email		
Home Address: Street	City	State	Zip		Home Phone No.	

SECTION II: RETIREE HEALTHCARE ENROLLMENT (NOTE: Refer to the 2019 Retiree Benefits Resources Guidebook for detailed information regarding the following plans.)

1. Medical Plan

I elect option: ☐ **KelseyCare** ☐ **High Deductible** ☐ **Low Deductible**

☐ Retiree Only

☐ Retiree + Spouse ☐ Retiree + Child(ren)

☐ Retiree + Family ☐ Decline / Cancel Coverage

2. Dental Plan

I elect: ☐ **HMO** ☐ **PPO**

☐ Retiree Only

☐ Retiree + Spouse ☐ Retiree + Child(ren)

☐ Retiree + Family ☐ Decline / Cancel Coverage

3. Vision Plan

I elect: ☐ **Vision**

☐ Retiree Only

☐ Retiree + Spouse ☐ Retiree + Child(ren)

☐ Retiree + Family ☐ Decline / Cancel Coverage

SECTION III: COVERED DEPENDENTS (For additional dependents, please add them on a separate sheet of paper and attach to this form.)

Name of Dependent (s) (Last, First, M.I.)	Gender	Date of Birth	Social Security No.	Relationship

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: _____