2020 Retiree Application and Change Form

Complete the information below to enroll in the 2020 Retiree Medical and/or Dental Plans. Individuals enrolling in the Medicare Advantage Plan must complete the Medicare Section and provide a copy of their Medicare Card. Rates and plan details are in the 2020 Retiree Benefit Guide.

Hire Date: _____ Retirement Date: _____ Retiree Coverage Effective Date: _____

Department: _____Reason for Change:_____

Retiree/Surviving Spouse Information

Last Name	First Name	MI
Mailing Address		Retiree 6 digit ID
City, State, Zip		Date of Birth

Address Change?	Email address	Phone Number:
☐ Yes ☐ No		Home:_____ Cell:_____

Retiree Eligibility

(read carefully)

Non-Medicare retirees, eligible spouses, and eligible dependents will only be permitted to enroll in the health plans offered through the City of Fort Worth if the retiree, spouse, or dependent is **NOT** eligible for group health coverage through another employer. To enroll you must confirm that each non-Medicare person for whom coverage is sought (retiree, spouse, dependent) is not eligible for group health coverage through a current employer.

Medicare eligible retirees and/or spouses may remain on the City's Medicare Advantage Plan. In the event a non-Medicare retiree has other coverage but their spouse is on Medicare, the spouse may remain on the City's Medicare Advantage Plan separate from the retiree.

Please check all applicable

☐ Ineligible for other coverage:
☐ I am **NOT** eligible for group health coverage through a current employer.
☐ My spouse is **NOT** eligible for group health coverage through a current employer.
☐ Each enrolled dependent is NOT eligible for group health coverage through a current employer.

Deferring coverage due to eligibility through current employer:

☐ I am deferring MY enrollment in retiree health insurance due to my being eligible for employer-based coverage and I am not covered by Medicare.
☐ I am deferring MY SPOUSE'S enrollment in retiree health insurance due to his/her eligibility or my eligibility for employer-based coverage and my spouse is not covered by Medicare.
☐ I am deferring my dependent(s) enrollment in retiree health insurance due to their eligibility for other employer-based coverage through myself or my spouse.

I understand that (i) as a Retiree who is not covered by Medicare *I must defer coverage* for myself if medical coverage is available to me through my employment and (ii) *I must defer coverage for my spouse* who is not covered by Medicare if medical coverage is available to my spouse through his/her employment. Following a deferral I will be able to enroll myself and/or my eligible spouse and dependents after other employer-based medical coverage ends *provided that* I request enrollment within 30 days of the end of such other coverage.

By submitting this form I acknowledge and affirm that **if I or my spouse becomes eligible for employer-based health insurance** during the coming year, **I am obligated to contact and will contact the Benefits Office within 30 days** of the coverage begin date to drop my Retiree Health Insurance.

Declining coverage for *any* reason other than the availability of employer-based coverage is a permanent decision, and you will not be permitted to re-enroll in the City's retiree insurance plan in the future.

Dependent Information

(You may only enroll eligible dependents enrolled at the time of your retirement)

Name	Relationship	Gender	Date of Birth MM/DD/YY	Coverage Elected	Deferred
Spouse: SSN:		☐ Female ☐ Male	/ /	☐ Medical ☐ Dental ☐ Vision	☐
Child: SSN:	☐ Child ☐ Stepchild ☐ Grandchild	☐ Female ☐ Male	/ /	☐ Medical ☐ Dental ☐ Vision	☐
Child: SSN:	☐ Child ☐ Stepchild ☐ Grandchild	☐ Female ☐ Male	/ /	☐ Medical ☐ Dental ☐ Vision	☐
Child: SSN:	☐ Child ☐ Stepchild ☐ Grandchild	☐ Female ☐ Male	/ /	☐ Medical ☐ Dental ☐ Vision	☐

Medical Plan

Select Plan	Select Coverage Level	
☐ Health Center Plan	☐ Retiree Only	☐ Surviving Spouse Only
☐ Consumer Choice Plan	☐ Retiree + Spouse	☐ Surviving Child(ren)
☐ AETNA Medicare Advantage Plan	☐ Retiree + Child(ren)	☐ Surviving Family
☐ Waive Coverage	☐ Retiree + Family	☐ Medicare Spouse

Dental plan

Select Plan		Select Coverage Level	
☐ DPPO High	☐ Waive Coverage	☐ Retiree Only	☐ Surviving Spouse Only
☐ DPPO Low		☐ Retiree + Spouse	☐ Surviving Child(ren)
☐ DHMO		☐ Retiree + Child(ren)	☐ Surviving Family
		☐ Retiree + Family	

Vision Plan

Select Plan		Select Coverage Level	
☐ Eyemed	☐ Waive Coverage	☐ Retiree Only	☐ Surviving Spouse Only
		☐ Retiree + Spouse	☐ Surviving Child(ren)
		☐ Retiree + Child(ren)	☐ Surviving Family
		☐ Retiree + Family	

Other Coverage Information

Other Insurance Company Name Policy Number	Employer
List Covered Dependents	

Medicare Coverage

Member Medicare Number	Part A Effective Date	Part B Effective Date
Spouse Medicare Number	Part A Effective Date	Part B Effective Date

Authorization

On behalf of myself and anyone enrolled on or added to this form ("us"), I authorize my health care professional or entity to give the Plan Claims Administrator, its affiliates and the Plan Sponsor, or any of their designees any and all records of information pertaining to medical history or services rendered to us for any administrative purposes, including evaluation of an application or a claim for any analytical or research purposes. I also authorize on behalf of us the use of a Social Security Number for purpose of identification. I understand and agree that any omissions or incorrect statements made on this application may invalidate the coverage of myself and my spouse and/or dependents. I further understand that coverage will become effective only on the date specified by the City of Fort Worth and after contributions have been made.

By signing this form I hereby certify that all the information provided is true and correct and acknowledge and agree that any intentional false statement in my enrollment or willful misrepresentation relative thereto may be subject to financial restitution and/or cancellation of coverage. I understand that I, as a covered retiree or survivor, will make contributions monthly from my retirement plan benefits or via direct payment. I understand the City reserves the right to conduct a benefit eligibility audit at any time.

Signature _____ Date _____