City of Austin 2012 Retiree Benefits Enrollment Form

Office Use	
Coverage Effective Date	
Manual Pymt Start Date	
Manual Pymt End Date	
Annuity Change Date	

◯ New Enrollment ◯ Open Enrollment ◯ Change Coverage ◯ Cancel Coverage

CITY COVERAGE - Do you have coverage with the City as an employee or a dependent of an active employee? ◯ YES ◯ NO

REASON FOR CHANGE _____

A: RETIREE DATA

SOC SEC NO	LAST NAME	FIRST NAME	MI	BIRTHDATE
ADDRESS	CITY		STATE	ZIP
COUNTY	HOME PHONE	◯ MALE ◯ FEMALE	◯ SINGLE ◯ MARRIED ◯ DOMESTIC PARTNER	
RETIREMENT DATE	◯ EMPLOYEES RETIREMENT SYSTEM	◯ FIRE RETIREMENT SYSTEM	◯ POLICE RETIREMENT SYSTEM	

What is your primary language if not English?

Do you have any disability that affects your ability to communicate or read?
If yes, what is the nature?

B: MEDICAL

UnitedHealthcare (Group No. 704244)

Do you want Retiree medical coverage? ◯ **YES** ◯ **NO** ◯ **Choice HMO (9)** ◯ **Choice Plus PPO (8)**

IMPORTANT: Persons eligible for Medicare due to age, must enroll in both Medicare Parts A & B.

Retiree Without Medicare		Retiree With Medicare	
◯ Only	A ____	◯ Only	B ____
◯ And Spouse/Domestic Partner w/out Medicare	C ____	◯ And Spouse/Domestic Partner with Medicare	D ____
◯ And Spouse/Domestic Partner with Medicare	E ____	◯ And Spouse/Domestic Partner w/out Medicare	F ____
◯ And Children	H ____	◯ And Children	G ____
◯ And Spouse/Domestic Partner w/out Medicare and Family	I ____	◯ And Spouse/Domestic Partner w/out Medicare and Family	K ____
◯ And Spouse/Domestic Partner with Medicare and Family	J ____	◯ And Spouse/Domestic Partner with Medicare and Family	L ____

Other Coverage - If you or your dependents listed in Section E have other medical coverage or Medicare, complete the section below.

Name of Policyholder	Insurance Co./ Medicare	Medicare Part A - Y/N	Medicare Part B - Y/N	Policy No./ Subscriber No.	Effective Date

C: DENTAL

Do you want Retiree dental coverage? ◯ **YES** ◯ **NO**

Assurant Employee Benefits Heritage Plus ◯ Ret. Only (A1) ◯ Ret. & 1 Dependent (A2) ◯ Ret. & Family (A3)

Delta Dental ◯ Ret. Only (I1) ◯ Ret. & 1 Dependent (I2) ◯ Ret. & Family (I3)

D: VISION

Do you want Retiree vision coverage? ◯ **YES** ◯ **NO**

Davis Vision ◯ Ret. Only (V1) ◯ Ret. & Spouse/Domestic Partner (V2) ◯ Ret. & Children (V3) ◯ Ret. & Family (V4)

E: DEPENDENT DATA

Name (Last, First, Middle)	Marriage Date (mm / dd / yy)	Social Security Number	Relation (Abbreviate)	Child Married (Y/N)	Birthdate (mm/dd/yy)	Sex (M/F)	Med (Y/N)	Den (Y/N)	Vision (Y/N)	IRS Dep (Y/N)	Add (A) Drop (D)

F: CONTRACT/ AUTHORIZATION

I certify that I have read the terms and conditions on the back of this form. I understand, acknowledge, and accept them.

SIGNATURE _____ DATE _____

08/11

Copy Distribution: HRD—White; Pension Office—Pink; TPA—Blue; Retiree—Gold

CONTRACT AGREEMENT AND PREMIUM DEDUCTION AUTHORIZATION

I certify that the information I have provided is true and correct and that I have not withheld information on this application. I am aware that any misrepresentation may cause my application to be rejected. I agree to comply with the rules set forth in the plan document(s) and/or insurance contract(s) for the plans offered by the City. I further authorize any physician and/or medical facility to release information about the health condition or treatment of myself and any dependent enrolled in the plan(s) to the Contractor upon request as necessary to determine what will be paid and to process the claim. I understand that my signature authorizes the appropriate premium deductions from my annuity for the coverage requested beginning on the effective date. I certify that the dependent(s) listed in Section E are eligible dependent(s) as defined in the plan document(s). For each individual who is not a dependent for Federal tax purposes, additional income will be reported to the IRS and applicable taxes withheld on the premium cost. I agree that I am responsible for paying health care expenses incurred by each person for whom I am buying coverage and agree to reimburse any incorrect benefits payments made directly to me. I understand that the City has the right to collect contributions owed. Conversely, I will be reimbursed if an overpayment occurs; however the City will only reimburse for up to 31 days of premiums. In addition, I hereby release the City from any liability that might be asserted against it in connection with its duties under this authorization.

INSTRUCTIONS FOR COMPLETING THE RETIREE BENEFITS ENROLLMENT FORM

City Coverage - Darken one oval, YES or NO, to indicate if you have coverage with the City as an Active employee or as a dependent of an active employee.

Reason for Change - Indicate the reason for changing coverage.

A: RETIREE DATA - Complete all the information requested.

B: MEDICAL - Darken one oval, YES or NO, to indicate if you wish to participate in Retiree medical coverage. If YES, darken one oval to indicate your choice between UnitedHealthcare HMO Choice or UnitedHealthcare PPO Choice Plus. Darken one oval to indicate your choice of coverage level. If **adding a Domestic Partner you must complete the Domestic Partner Affidavit and the Tax Dependent Status Form.**

Other Coverage - Retirees and their dependents who are eligible for Medicare must enroll in both Medicare Parts A & B. Complete this section only if you or your covered dependents have other medical coverage or Medicare in addition to the medical coverage selected on this form.

C: DENTAL - Darken one oval, YES or NO, to indicate if you wish to participate in Retiree dental coverage. If YES, darken one oval to indicate your choice of plan and coverage level. If **adding a Domestic Partner you must complete the Domestic Partner Affidavit and the Tax Dependent Status Form.**

D: VISION - Darken one oval, YES or NO, to indicate if you wish to participate in vision coverage. If YES, darken one oval to indicate your choice of coverage level. If **adding a Domestic Partner you must complete the Domestic Partner Affidavit and the Tax Dependent Status Form.**

E: DEPENDENT DATA - Complete this section if any of your choices in Section B, C, and D include coverage for your dependents. List each dependent and complete each box on the rows where you have written a dependent's name. Use the first line for your spouse's data, if applicable, and remember to include your date of marriage.

For IRS dependent, indicate whether this person qualifies as a dependent on your Federal income tax return by writing "Y" for YES or "N" for NO. The instructions for Form 1040 or 1040A (available through the IRS) explain who is an eligible IRS dependent. Your spouse is always considered an IRS dependent even though you may be filing separate tax returns.

For each new dependent you are enrolling (currently not covered), write Add in the last column. To drop coverage for a dependent you currently cover, write Drop in the last column.

If you have more than six dependents, you will need to complete two Retiree Benefits Enrollment Forms. On the first form, complete all sections. On the second form, complete your name and Social Security number in Section A and complete Section E for additional dependents. Sign and date both forms and attach the second form to the first.

F: CONTRACT/AUTHORIZATION - Read the CONTRACT AGREEMENT AND PREMIUM DEDUCTION AUTHORIZATION statement at the top of this page. After reading the statement, be sure to sign and date the front of this form. **Your benefits choices cannot become effective if your form is not signed and dated.**