RETIREE BENEFITS CHANGE FORM

First Name MI Last Name	Social Security Number	Retirement Date:
Street Address	City/State/Zip	Home Phone
Change Reason (Qualifying Event)		Effective Date of Change:

MEDICAL, DENTAL, VISION ELECTION

PLAN LEVELS	Aetna Select	Aetna POS II	MEDICARE ADVANTAGE	Dental	Vision Basic	Vision High	Life Insurance
Retiree Only	☐	☐	☐	☐	☐	☐	☐
Retiree & Family	☐	☐	☐	☐	☐	☐	N/A
Retiree & Spouse	☐	☐	☐	N/A	N/A	N/A	N/A
Retiree & Children	☐	☐	☐	N/A	N/A	N/A	N/A
Decline	☐	☐	☐	☐	☐	☐	☐

MEDICARE INFORMATION:

IMPORTANT! When you become eligible for Medicare, whether from turning 65 or due to disability, Medicare becomes your primary insurance.

Do you, your spouse or your dependent(s) have Medicare? Yes ☐ No ☐ If yes, please provide the following information and a copy of your Medicare card.

Retiree Medicare Effective Date: A:_____B:_____ Medicare Claim ID # _____

Spouse Medicare Effective Date: A:_____B:_____ Medicare Claim ID# _____

Dependent Medicare Effective Date: A:_____B:_____ Medicare Claim ID# _____

FAMILY INFORMATION

(Below place an "A" to Add "R" to Remove)

Last Name, First Name, MI	SSN	Date Of Birth	Relationship (S)pouse D)ependent	Sex Male Female	Medical A R	Dental A R	VSP Basic A R	VSP High A R
Spouse								
Dependent(s)								

OTHER INSURANCE

Is your Spouse Employed? ☐ Yes ☐ No	If yes, please give name and address of spouse's employer.
Does your spouse have health insurance? ☐ Yes ☐ No	If yes, please give name and policy number of insurance carrier or other HMO. If yes, who is covered by this policy? ☐ Yourself ☐ Yourself/Spouse ☐ Spouse only ☐ Entire Family

_____ SIGNATURE

_____ PRINTED NAME

_____ DATE

AUTHORIZATION TO OBTAIN OR RELEASE MEDICAL INFORMATION: I authorize any health care professional or entity to give the health plan/insurer or any of their designees, any and all records or information pertaining to medical history or services rendered to us for any administrative purpose, including evaluation of an application or a claim, and for any analytical or research purposes. I also authorize the use of a Social Security Number for purpose of identification.

OVERAGE DEPENDENT VERIFICATION: If any dependent (not including your spouse), listed above is 26 or older, the appropriate Overage Dependent Affidavit (26-30) must be completed and returned to Human Resources for coverage to become effective.

IMPORTANT INFORMATION: Evidenced by my signature on the other side, I affirm that all information is accurate and complete. I understand and agree that any omissions or incorrect statements made by me on this application may invalidate my dependents' and/or my coverage. I understand that any person who knowingly and with intent to injure, defraud, or deceive any insurer, files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree. I understand that coverage will become effective only on the date specified by the Insurer after the application has been approved by the Insurer and after the first full premium has been paid.