LEE COUNTY
SOUTHWEST FLORIDA
Board of County Commissioners
Department of Human Resources

# 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 |
|---|---|---|---|---|---|---|
| Retiree Only | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Retiree & Family | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Retiree & Spouse | ☐ | ☐ | ☐ | N/A | N/A | N/A |
| Retiree & Children | ☐ | ☐ | ☐ | N/A | N/A | N/A |
| Decline | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

Retiree Medicare Eff: _____

Spouse Medicare Eff: _____

Medicare Claim ID#: _____
*(number on <u>your</u> Medicare card)*

Medicare Claim ID#: _____
*(number on <u>covered spouse</u> Medicare card)*

*NOTE: If you are electing the Medicare Advantage Plan, you are REQUIRED to provide Medicare ID numbers for <u>ALL</u> covered individuals.*

Dependent Medicare Eff: _____
*(number on <u>covered Dependent</u> Medicare card)*

## FAMILY INFORMATION

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

| Last Name, First Name, MI | SSN | Date Of Birth | Relationship<br>☐ (S)pouse<br>☐ (D)ependent | Sex<br>☐ M<br>☐ F | Medical<br>A<br>R | Dental<br>A<br>R | VSP Basic<br>A<br>R | VSP High<br>A<br>R |
|---|---|---|---|---|---|---|---|---|
| Spouse | | | | | | | | |
| Dependent(s) | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |

## OTHER INSURANCE

| | |
|---|---|
| Is your Spouse Employed?<br>☐ Yes ☐ No | If yes, please give name and address of spouse's employer. |
| Does your spouse have health insurance?<br>☐ Yes ☐ No | If yes, please give name and policy number of insurance carrier or other HMO.<br>If yes, who is covered by this policy?<br>☐ 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 19 or older, the appropriate Overage Dependent Affidavit (19-25 or 25-30) 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.