

2022 CITY OF GREEN BAY RETIREE INSURANCE BENEFITS ENROLLMENT FORM



GENERAL RETIREE INFORMATION

Please only fill out this form and send in, if you are making changes to your current coverage

Retiree Name: _____ Date of Birth _____ Person Insured : _____ Social Security # _____ Dept.: _____ Spouse Name: _____ Date of Birth: _____ Home Address _____ <div style="display: flex; justify-content: space-between; width: 100%;"> Street Address City State Zip </div> Home Phone (____) _____ Home E-mail _____	Updated Ins. Vendor: ____/____/____ Robo City: ____/____/____ EBC ____/____/____ Terminate out of deferred comp. if applicable ____/____/____
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Please use my Escrow dollars to pay for the City's Health and/or Dental plan, upon enrollment.

PURPOSE OF COMPLETING FORM (Check one option below)

Date of Retirement: : ____/____/____ <input type="checkbox"/> Enroll in Retirement Plan <input type="checkbox"/> Termination of Retiree Coverage <input type="checkbox"/> Termination of Dependent Coverage Only <input type="checkbox"/> Termination of Retiree & Dependent Coverage Name of person(s) terming: _____	Effective date of change : ____/____/____ Status Change: <input type="checkbox"/> Birth <input type="checkbox"/> Marriage <input type="checkbox"/> Adoption <input type="checkbox"/> Divorce <input type="checkbox"/> Court Ordered Dependent <input type="checkbox"/> Other _____
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ELECTION AUTHORIZATION

I understand by signing this form, I am making a binding election for my benefits. I recognize completion of this form does not guarantee eligibility for a plan. I further understand I may not change my benefit elections except during the annual open enrollment or within 30-calendar days of a qualifying life event. In the event of a qualifying life event I understand it is my responsibility to notify Human Resources in writing within 30-calendar days of the qualifying event.

Retiree Signature _____ **Date** _____

This Enrollment Form explains the general purpose of the insurance described, but in no way changes or affects the policy(s) actually issued. In the event of any discrepancy between this document and the policy, the terms of the policy apply. The benefit product contains limitations and exclusions, complete coverage information can be found in your Booklet-Certificate if you become insured. Please read it carefully and keep it in a safe place with your other important papers.

NAME:

DATE:

HEALTH INSURANCE

Check the box for the health coverage requested.

I **Elect** one of the two following **Health** insurance options:

PPO Health Plan	<input type="checkbox"/> Single - \$2250 Deductible	N/A	<input type="checkbox"/> Family - \$4500 Deductible
Retiree Health Plan	<input type="checkbox"/> Single - \$2000 Deductible	<input type="checkbox"/> Single+1 - \$4000 Deductible	<input type="checkbox"/> Family - \$5000 Deductible

I would like to **Terminate** the following health insurance coverage.

Active Employee Health Plan	<input type="checkbox"/> Single - \$2250 Deductible	N/A	<input type="checkbox"/> Family - \$4500 Deductible
Retiree Health Plan	<input type="checkbox"/> Single - \$2000 Deductible	<input type="checkbox"/> Single+1 - \$4000 Deductible	<input type="checkbox"/> Family - \$5000 Deductible

If you are applying for coverage for your **spouse and/or dependent(s)** please provide the information requested.

Name (First, Middle Initial, Last)	Relationship	Date of Birth	Female/Male	Social Security Number

DENTAL INSURANCE

I **Elect** the following **Dental** Insurance Coverage: Check only one of the following boxes for dental coverage.

<input type="checkbox"/> Single Dental Associates <input type="checkbox"/> Family Dental Associates	<input type="checkbox"/> Single Delta Dental <input type="checkbox"/> Family Delta Dental
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I would like to **Terminate** the following dental insurance coverage as of _____

<input type="checkbox"/> Single Dental Associates <input type="checkbox"/> Family Dental Associates	<input type="checkbox"/> Single Delta Dental <input type="checkbox"/> Family Delta Dental
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If you are applying for coverage for your **spouse and/or dependent(s)** please provide the information requested.

Name (First, Middle Initial, Last)	Relationship	Date of Birth	Female/Male	Social Security Number

Retiree Signature _____ Date _____