



# 2012 Medical Plan Election Form for Retirees Age 65 and Older

Please print all information in ink and remember to sign and date the form.

You can mail or fax this form to  
EBPA:

EBPA  
37 Industrial Drive, Suite E  
Exeter, NH 03833  
Fax: (603) 773-4410

Last Name:		First Name:	
Social Security Number:	- -	Date of Birth:	- -
Home Address:			
Home Phone:	- -	Retirement Date:	- -

I elect the following Retiree Medical Plan to be effective: January 1, 2012

<input type="checkbox"/> United Healthcare (UHC) SecureHorizons (Medicare Advantage) – Complete UHC Form	<input type="checkbox"/> CIGNA Plan B Indemnity
<input type="checkbox"/> Aetna Medicare Medicare Advantage (PPO) – Complete Aetna Form	<input type="checkbox"/> United Healthcare (UHC) POS 100
<input type="checkbox"/> I waive coverage at this time	

COVERAGE LEVEL: Please check all boxes that apply.	<input type="checkbox"/> Yourself	<input type="checkbox"/> Spouse/Same-Sex Domestic Partner
	<input type="checkbox"/> Surviving Dependent of University Retiree	

If you require split coverage because your spouse or eligible dependent is under age 65 and not eligible for the same plan as you, please also complete and return the *Medical Plan Election Form for Retirees Under Age 65*.

## Dependent Information

**Please Note:** Only the spouse/same-sex domestic partner who was your dependent when you retired will be eligible for medical benefits after you retire. However, you may continue to add new dependent children to your coverage. Enter information for all dependents you will cover. You must be prepared to provide proof of each dependent's eligibility.

Dependent #1: Name:			
Social Security Number:	- -	Relationship:	Date of Birth: - -
Dependent #2: Name:			
Social Security Number:	- -	Relationship:	Date of Birth: - -
Dependent #3: Name:			
Social Security Number:	- -	Relationship:	Date of Birth: - -

*I understand that I and any dependents who are eligible for Medicare must have Medicare Part A and Part B as our primary insurer when we reach age 65.*

*I understand that if I waive my Columbia University Retiree Medical Coverage at this time, future eligibility will be determined upon the terms of the retiree medical plan in effect at the time and will be required to provide proof of continuous medical coverage.*

Retiree Signature: \_\_\_\_\_ Date (mm/dd/yyyy): \_\_\_\_\_