



# 2012 Medical Plan Election Form for Retirees Under Age 65

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

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

You can mail or fax this form to EBPA:

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"/> Aetna POS 90	<input type="checkbox"/> UHC POS 90
<input type="checkbox"/> CIGNA POS 90	<input type="checkbox"/> UHC POS 100
<input type="checkbox"/> CIGNA POS 100	<input type="checkbox"/> CIGNA Plan B (Indemnity)
<input type="checkbox"/> I waive coverage at this time	

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

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

## 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 if you are selected for an audit.

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 when I and any dependents become eligible for Medicare, we 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 I may be required to provide proof of continuous medical coverage.*

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