

2015 Health Plan Election Form for Retirees Age 65 and Older

Please print all information and sign and date the form. <input type="checkbox"/> Open Enrollment <input type="checkbox"/> New Enrollment <input type="checkbox"/> Qualified Life Status Change		Fax or mail this form to: EBPA 37 Industrial Drive Exeter, NH 03833-4593 Secure Fax: (603) 773-4410	
Last Name:		First Name:	
Social Security Number: - -		Date of Birth: - -	
Mailing Address:			
Telephone Number: - -		Retirement Date: - -	
I elect the following Retiree Medical Plan to be effective January 1, 2015			
<input type="checkbox"/>	UnitedHealthCare Group (Medicare Advantage – HMO) Complete UHC Enrollment Application	<input type="checkbox"/>	Indemnity Plan (UHC)
<input type="checkbox"/>	Aetna Medicare (Medicare Advantage – PPO or ESA) Complete Aetna Enrollment Application	<input type="checkbox"/>	Choice Plus 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/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 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 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 enroll in Medicare Part A and Part B as our primary insurer.

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 must be able to provide proof of continuous medical coverage.

Retiree Signature: _____ Date (mm/dd/yyyy): _____