COLUMBIA UNIVERSITY
HR Benefits

2015 Health Plan Election Form for Retirees Under Age 65

Please print all information and sign and date the form. ❑ Open Enrollment ❑ New Enrollment ❑ Qualified Life Status Change	Fax or mail this form to: EBPA 37 Industrial Drive Exeter, NH 03833-4410 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

❑ Choice Plus 80
❑ Choice Plus 90
❑ Choice Plus 100
❑ I waive coverage at this time

COVERAGE LEVEL: Please check all boxes that apply	❑ Yourself	❑ Spouse/ Domestic Partner
	❑ Dependent Child(ren)	❑ Surviving Dependent of University Retiree

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 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):*** ____________