CITY OF GREEN BAY RETIREE INSURANCE BENEFIT FORMS FOR CALENDAR YEAR 2020

GENERAL RETIREE INFORMATION

Retiree Name: _____ Date of Birth _____

Person Insured : _____

Social Security # _____ Dept.: _____

Spouse Name: _____ Date of Birth: _____

Home Address _____
Street Address City State Zip

Home Phone (_____)_____ Home E-mail _____

Updated Ins. Vendor:

____/____/____

Robo City:

____/____/____

Benefit Advantage (BA)

____/____/____

Terminate out of ICMA if applicable

____/____/____

☐ **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: : _____/_____/_____

Effective date of change : _____/_____/_____

☐ Enroll in Retirement Plan

☐ Termination of ***Retiree*** Coverage

☐ Termination of ***Dependent*** Coverage Only

☐ Termination of ***Retiree & Dependent*** Coverage

Name of person(s) terming: _____

Status Change:

☐ Birth ☐ Marriage ☐ Adoption ☐ Divorce

☐ Court Ordered Dependent

☐ Other _____

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:

Active Employee Health Plan	☐ Single - $2250 Deductible	N/A	☐ Family - $4500 Deductible
Retiree Health Plan	☐ Single - $2000 Deductible	☐ Single+1 - $4000 Deductible	☐ Family - $5000 Deductible

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

Active Employee Health Plan	☐ Single - $2250 Deductible	N/A	☐ Family - $4500 Deductible
Retiree Health Plan	☐ Single - $2000 Deductible	☐ Single+1 - $4000 Deductible	☐ 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.

☐ **Single Dental Associates**	☐ **Single Humana Dental**
☐ **Family Dental Associates**	☐ **Family Humana Dental**

I would like to ***Terminate*** the following dental insurance coverage as of _____

☐ **Single Dental Associates**	☐ **Single Humana Dental**
☐ **Family Dental Associates**	☐ **Family Humana Dental**

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** _____

This Enrollment Form explains the general purpose of the insurance described, but in no way changes or affects the policy as it is actually issued. In the event of any discrepancy between this document and the policy, the terms of the policy apply. The LTD 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.