Benefits Election / Change Form – Retiree

January 1, 2019 – December 31, 2019

Check The Appropriate Box			
☐ Initial Enrollment ☐ Open Enrollment	☐ Marriage ___ ___ / ___ ___ / ___ ___ ☐ Birth / Adoption ___ ___ / ___ ___ / ___ ___	☐ Divorce Date ___ ___ / ___ ___ / ___ ___ ☐ Date of Death ___ ___ / ___ ___ / ___ ___	☐ Cancel Coverage ☐ Other ___________________

Employee Information				
Last Name	First Name	Initial	Social Security Number ___ ___ ___ - ___ ___ - ___ ___ ___ ___	
Physical Street Address	City	State	Zip Code	
Mailing Street Address	City	State	Zip Code	
Home Telephone (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___	Work Phone (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___	Email Address		
Date of Birth ___ ___ / ___ ___ / ___ ___ ___ ___	Date of Retirement ___ ___ / ___ ___ / ___ ___ ___ ___	Effective Date ___ ___ / ___ ___ / ___ ___ ___ ___	Marital Status	Sex

Benefit Elections - Refer to the Rate Sheet for AZ and Non AZ Rates							
Retired Employees	CIGNA Medical Policy# 3328775						
Plan Options	Medicare Surround		Arizona		Non Arizona		
Plan Selection	☐		☐ CDHP	☐ OAP	☐ CDHP	☐ OAP	
Retiree: Medicare Part A & B	Enrolled ☐	Not Enrolled ☐					
Spouse: Medicare Part A & B	Enrolled ☐	Not Enrolled ☐	N/A ☐				

Please complete for yourself and each of your eligible dependents

Check Appropriate Box	First Name, Initial, Last Name / Social Security Number	Sex	Date of Birth	Relationship Type	Coverage Elected
☐ Enroll ☐ Cancel ☐ Change	 SS#___ ___ ___ - ___ ___ - ___ ___ ___ ___		___/___/___	☐ Self	Surround ☐ OAP ☐ CDHP ☐
Children are eligible for coverage up to age 26					
☐ Enroll ☐ Cancel ☐ Change	 SS#___ ___ ___ - ___ ___ - ___ ___ ___ ___		___/___/___	☐ Spouse ☐ Domestic Partner	Surround ☐ OAP ☐ CDHP ☐
☐ Enroll ☐ Cancel ☐ Change	 SS#___ ___ ___ - ___ ___ - ___ ___ ___ ___		___/___/___		OAP ☐ CDHP ☐
☐ Enroll ☐ Cancel ☐ Change	 SS#___ ___ ___ - ___ ___ - ___ ___ ___ ___		___/___/___		OAP ☐ CDHP ☐
☐ Enroll ☐ Cancel ☐ Change	 SS#___ ___ ___ - ___ ___ - ___ ___ ___ ___		___/___/___		OAP ☐ CDHP ☐
☐ Enroll ☐ Cancel ☐ Change	 SS#___ ___ ___ - ___ ___ - ___ ___ ___ ___		___/___/___		OAP ☐ CDHP ☐
☐ Enroll ☐ Cancel ☐ Change	 SS#___ ___ ___ - ___ ___ - ___ ___ ___ ___		___/___/___		OAP ☐ CDHP ☐

(Over)

Other Coverage Information

On the day coverage begins will you or any of your eligible dependents be covered by any other insurance?
☐ Yes ☐ No If yes, please complete the information below. Use an additional sheet if more than one additional policy will be in force.

Coverage ☐ Medical / Medicare	Insurance Company Name	Phone Number (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___	Group Number	Policy Number

Policy Coverage Dates _____ to _____	Policy Holder Name	Social Security Number ___ ___ ___ - ___ ___ - ___ ___ ___ ___

Family Members Covered	Medicare Card Number	Effective Date
_____ _____		Part A: ___ ___ / ___ ___ / ___ ___
_____ _____		Part B: ___ ___ / ___ ___ / ___ ___

Certification and Authorization

I certify that all information on this form is true and complete to the best of my knowledge.

RETIREE SIGNATURE:	DATE: