2022 RETIREE ENROLLMENT/CHANGE FORM

Please retain a copy for your records.

Complete the information below to enroll/drop/change the following 2022 benefit plans: **Retiree Dental, Retiree Vision**, and **Under Age 65 Retiree Medical & Pharmacy.** Failure to return this form within the appropriate timeframe could result in loss of coverage for you and your dependents. All retirees and dependents must provide a Social Security Number to enroll. Rates and plan details are in the 2022 Retiree Benefit Guide. Retirees and/or dependents enrolling in a City plan AND who are eligible for Medicare must complete the Medicare Section and provide a copy of your Medicare Card.

Enrollment in Age 65+ Retiree Medicare insurance plans will be administered by United Healthcare Medicare Solutions Connector Model.

Effective Date: _____

RETIREE/SURVIVING SPOUSE INFORMATION

Last Name:	First Name:	Middle Initial:	Check one: ☐ Retiree ☐ Surviving Spouse
If Surviving Spouse, enter name of City Retiree:			
Mailing Address:			Social Security Number:
City/State/ZIP code:			Date of Birth:
Address Change? ☐ Yes ☐ No	Email Address:		Home/Cell Number:

RETIREE ELIGIBILITY

Retirees and eligible dependents will be permitted to enroll in retiree insurance offered through the City if the retiree is **not** eligible for group health coverage through another employer. To enroll yourself (and, if applicable, your dependents) in retiree insurance through the City, you must confirm that you are not eligible for group health coverage through a current employer. Retirees eligible for other coverage must complete the Waiver section on the back of this form.

☐ I am **not** eligible for group health coverage through a current employer.*

*Note-If at any time you become eligible for group employer health coverage, you must contact the City of Arlington.

DEPENDENT INFORMATION (Complete for dependents you wish to enroll or drop benefits plans)

Medical	Dental	Vision	Action A=ADD D=DROP NC=NO CHANGE	NAME – PLEASE PRINT (Last, First, MI)	Relationship SP = SPOUSE D = DAUGHTER S = SON	Social Security Number	Date of Birth

IMPORTANT: Documentation is required when adding coverage. Refer to the Retiree Benefit Guide for details.

MEDICARE INFORMATION – Must provide a copy of Medicare card to Human Resources

Name – PLEASE PRINT *(Last, First, Middle Initial)*	Relationship:	Eligible Date:	Effective Date:	Medicare Number:	Part A:	Part B:	Part D:
					☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
					☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

FOR OFFICE USE ONLY:

LAWSON #:		MEDICAL:		CONTACT INFO UPDATED:	
RETIREMENT DATE:		DENTAL:		DOCUMENTATION:	
EFFECTIVE DATE:		VISION:		FINANCE:	
LAWSON UPDATED:		PAYMENT METHOD:	☐ ACH ☐ TMRS ☐ Other	YOS:	

UNDER AGE 65 UNITED HEALTHCARE MEDICAL & PHARMACY PLANS

Select plan:	Select coverage level:	Enter monthly cost:
☐ Value (High Deductible Health Plan) ☐ Core (Exclusive Provider Plan) ☐ **I decline MEDICAL coverage for:** ☐ Myself ☐ My spouse ☐ My dependent children Due to: ☐ existence of other coverage ☐ don't want/need	☐ Retiree only ☐ Surviving Spouse only ☐ Retiree & Spouse ☐ Retiree & Family ☐ Retiree & Child(ren) ☐ Spouse only (Retiree is age 65 or older) ☐ Spouse or Surviving Spouse + Child(ren)	$_____ NOTE: Refer to 2022 Retiree Benefit Guide for rates. www.arlingtontx.gov

SUPERIOR VISION PLANS

Select plan:	Select coverage level:		
Plan Name:	Retiree only (no dependents)	Retiree + 1 dependent:	Retiree + 2 or more dependents:
☐ Low Vision	☐ $ 4.27	☐ $ 8.87	☐ $ 13.53
☐ High Vision	☐ $ 4.86	☐ $ 10.11	☐ $ 15.43
☐ **I decline VISION coverage for:** ☐ Myself ☐ My spouse ☐ My dependent children			**Enter monthly cost:** $_____

DELTA DENTAL PLAN

Select plan:	Select coverage level:		
Plan Name:	Retiree only (no dependents)	Retiree + 1 dependent:	Retiree + 2 or more dependents:
☐ DHMO (DeltaCare)	☐ $ 11.76	☐ $ 23.71	☐ $ 35.58
☐ Low PPO	☐ $ 14.98	☐ $ 29.68	☐ $ 52.25
☐ High PPO	☐ $ 36.15	☐ $ 71.56	☐ $ 125.94
☐ **I decline DENTAL coverage for:** ☐ Myself ☐ My spouse ☐ My dependent children			**Enter monthly cost:** $_____

MONTHLY COST – Payable to the City of Arlington

Enter the monthly cost of each plan you have selected:

$_____ + $_____ + $_____ = $_____

Under Age 65 Medical *Vision* *Dental* *Total Monthly Cost*

MAILING ADDRESSES

*Mail your **Enrollment/Change Form** to:*
City of Arlington Benefits - MS 63-0790
PO Box 90231
Arlington, TX 76004-3231

*Mail your **monthly payments** to:*
City of Arlington Finance Dept. - MS 63-0820
PO Box 90231
Arlington, TX 76004-3231

WAIVER

I understand that as a Retiree, if I waive coverage because of other health, dental, or vision coverage, I may in the future be able to enroll myself and my eligible dependents, provided that I request enrollment and submit required documents within 30 days after such coverage ends.

☐ I decline to enroll MYSELF in retiree insurance (____Health ____Dental ____Vision) due to being eligible for employer-based coverage.*
☐ I decline to enroll my SPOUSE in retiree insurance (____Health ____Dental ____Vision) due to being eligible for employer-based coverage.*
☐ I decline to enroll my CHILDREN in retiree insurance (____Health ____Dental ____Vision) due to being eligible for employer- based coverage.*

***NOTE: Waiver of coverage for any other reason is a permanent waiver and you will not be permitted to re-enroll in the City's retiree insurance plans**.

Signature _____ Date _____

SIGNATURES

My signature below affirms that my benefit enrollment includes only those dependents that meet the City of Arlington eligibility guidelines and that all information provided above is true and correct. I understand that any intentional false statement in my enrollment or willful misrepresentation relative thereto may be subject to financial restitution and/or cancellation of all coverage.

_____ _____

Retiree *Date* *Human Resources* *Date*