



CITY OF MEMPHIS 2015 RETIREE DENTAL AND VISION ENROLLMENT/CHANGE FORM

Retiree Information

Social Security No. ____-____-____	City Oracle ID No.	Gender: _____ Male _____ Female	Effective Date of Enrollment/Change:
**Last name: If Applicable Name must match Medicare Health Insurance Card		First name:	Middle initial
Permanent residence street address (P.O. box is not allowed):			
City:	State:	ZIP code:	County:
Email address:			

C. REASON FOR ENROLLMENT/CHANGE:

I am enrolling during Annual Enrollment Qualifying Life Event (QLE)*

*You must submit this form along with required documentation within 60 days of the event date. Please Provide QLE and date of event:

D. BENEFIT ELECTION – Check One Per Benefit

Dental Plan	Enroll: _____ Basic _____ Premier _____ Primary _____ Waive _____ Cancel _____ No Change	_____ Retiree Only _____ Retiree +1 _____ Retiree + Family
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Family Members to be Covered in Dental Plan:

Name	Social Security Number	Date of Birth	Gender	Relationship

Vision Plan	Enroll: _____ Exam and Matierals _____ Materials Only _____ Waive _____ Cancel _____ No Change	_____ Retiree Only _____ Retiree +1 _____ Retiree + Family
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Family Members to Be Covered In Vision Plan:

Name	Social Security Number	Date of Birth	Gender	Relationship

Retiree /Surviving Spouse Signature: _____ Date: _____