



CITY OF MEMPHIS 2015 RETIREE MEDICAL PLAN 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:
A. REASON FOR ENROLLMENT/CHANGE:				
<input type="checkbox"/> I am enrolling during Annual Enrollment <input type="checkbox"/> 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:				
B. BENEFIT ELECTION – MEDICAL PLAN				
<input type="checkbox"/> I Decline City Medical Coverage <input type="checkbox"/> I Elect to keep my City of Memphis Coverage with NO changes, but agree to pay the full premium under “Access Only” coverage.				
Retiree Section	Spouse Section	Dependent Section		
____ Basic ____ Premier ____ Check here if Retiree is entitled to City Subsidy	____ Basic ____ Premier ____ Check here if Spouse is entitled to City Subsidy	____ Basic ____ Premier ____ Check here if Dependent is entitled to City Subsidy		
Medicare Supplement: ____ Plan F ____ Plan G ____ Plan N	Medicare Supplement: ____ Plan F ____ Plan G ____ Plan N	Medicare Supplement: ____ Plan F ____ Plan G ____ Plan N		
Medicare Part D: ____ Rx Plan 1 -\$10/20/40/40 (w/ donut hole coverage) ____ Rx Plan 2 -\$10/30/50/70 (w/donut hole coverage) ____ Rx Plan 3 -\$10/20/40/40 (w/out donut hole coverage) ____ Rx Plan 4 -\$10/30/50/70 (w/out donut hole coverage)	Medicare Part D: ____ Rx Plan 1 -\$10/20/40/40 (w/ donut hole coverage) ____ Rx Plan 2 -\$10/30/50/70 (w/donut hole coverage) ____ Rx Plan 3 -\$10/20/40/40 (w/out donut hole coverage) ____ Rx Plan 4 -\$10/30/50/70 (w/out donut hole coverage)	Medicare Part D: ____ Rx Plan 1 -\$10/20/40/40 (w/ donut hole coverage) ____ Rx Plan 2 -\$10/30/50/70 (w/donut hole coverage) ____ Rx Plan 3 -\$10/20/40/40 (w/out donut hole coverage) ____ Rx Plan 4 -\$10/30/50/70 (w/out donut hole coverage)		
Medicare Advantage: ____ MA-Mid-Plan with \$10/25/50 rx ____ MA High- Plan with \$5/10/25 rx	Medicare Advantage: ____ MA-Mid-Plan with \$10/25/50 rx ____ MA High- Plan with \$5/10/25 rx	Medicare Advantage: ____ MA-Mid-Plan with \$10/25/50 rx ____ MA High- Plan with \$5/10/25 rx		
Please provide the information below for the Retiree and/or Spouse enrolling in the Medicare Plans				
Retiree Medicare Claim Number: ____ - ____ - ____		Hospital Part A effective date: Medical Part B effective date: Primary Doctor’s Name & ID. NO.:		
Spouse’s Name:		Spouse’s Social Security Number: ____ - ____ - ____		
Spouse Medicare Claim Number: ____ - ____ - ____		Hospital Part A effective date: Medical Part B effective date: Primary Doctor’s Name & ID. NO.:		
Please list the information below for each Dependent enrolling:				
Name	Gender	Social Security No.	Medicare Claim No.	Primary Doctor’s Name & ID. NO. (Listed in Cigna Directory)
1. _____	_____	1. _____	1. _____	1. _____
2. _____	_____	2. _____	2. _____	2. _____

Retiree /Surviving Spouse Signature: _____ Date: _____

Spouse Signature: _____ Date: _____