



# CITY OF MEMPHIS 2016 RETIREE MEDICAL PLAN

## ENROLLMENT/CHANGE FORM

### (MEDICARE PARTS A&B)

#### Retiree Information

Social Security No. ____ - ____ - _____	Date of Birth: ____/____/____	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: Telephone Number: _____

#### A. REASON FOR ENROLLMENT/CHANGE:

I am enrolling during Annual Enrollment    
  Qualifying Life Event (QLE)\*    
  I Decline City Medical Coverage

\*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 PLANS

Retiree Section	Spouse Section	Dependent Section
<b>Medicare Supplement:</b> _____ Plan F _____ Plan G _____ Plan N  _____ I Decline the Supplemental plans for Retiree	<b>If spouse does not have Medicare , you must complete the No Medicare form</b> <b>Medicare Supplement:</b> _____ Plan F _____ Plan G _____ Plan N  _____ I Decline the Supplemental plans for Spouse	<b>If dependent does not have Medicare , you must complete the No Medicare form</b> <b>Medicare Supplement:</b> _____ Plan F _____ Plan G _____ Plan N  _____ I Decline the Supplemental plans for Dependent
<b>Medicare Part D:</b> _____ 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) _____ I Decline the RX plans for Retiree	<b>Medicare Part D:</b> _____ 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) _____ I Decline the RX plans for Spouse	<b>Medicare Part D:</b> _____ 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) _____ I Decline the RX plans for Dependent
<b>Medicare Advantage:</b> _____ MA-Mid-Plan with \$10/25/50 RX _____ MA High- Plan with \$5/10/25 RX _____ I Decline the MA Plan for Retiree	<b>Medicare Advantage:</b> _____ MA-Mid-Plan with \$10/25/50 RX _____ MA High- Plan with \$5/10/25 RX _____ I Decline the MA Plan for Spouse	<b>Medicare Advantage:</b> _____ MA-Mid-Plan with \$10/25/50 RX _____ MA High- Plan with \$5/10/25 RX _____ I Decline the MA Plan for Dependent

#### 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: MA 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: MA Primary Doctor's Name & ID. NO.:

#### Please provide the information below for each dependent to be covered. If you do not list a dependent, they will not be covered:

Name	Gender	Social Security No.	Medicare Effective Date & Claim No.
1. _____	_____	1. _____	1. _____
2. _____	_____	2. _____	2. _____

Retiree /Surviving Spouse Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Spouse Signature: \_\_\_\_\_ Date: \_\_\_\_\_



# CITY OF MEMPHIS 2016 RETIREE MEDICAL PLAN

## ENROLLMENT/CHANGE FORM

**(No Medicare, Medicare A Only, Medicare B Only or Line of Duty)**

### Retiree Information

Social Security No. ____-____-____	Date of Birth: ____/____/____	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:	Telephone Number:
-------	--------	-----------	---------	-------------------

### B. 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:

### C. BENEFIT ELECTION – MEDICAL PLAN

I elect to enroll as "Access Only"  I Decline City Medical Coverage  I am a City of Memphis Grandfathered Retiree\* or Retiree Survivor\*

\*Grandfathered Retiree or Retiree Survivor is entitled to City Subsidy if status is No Medicare, Medicare A Only, Medicare B Only or Line of Duty

Retiree Section	Spouse Section	Dependent Section
____ Basic ____ Premier  ____ I Decline the medical coverage for Retiree	If spouse has Medicare , you must complete the Medicare form ____ Basic ____ Premier  ____ I Decline the medical coverage for Spouse	If dependent has Medicare , you must complete the Medicare form ____ Basic ____ Premier  ____ I Decline the medical coverage for Dependent

### Please provide the information below for the Spouse or Dependents enrolling in the Medical Plans

Last Name	First Name	M.I.	Social Security Number	Gender	Relationship

### D. OTHER INSURANCE COVERAGE INFORMATION

Do you or any of your covered dependents have other medical coverage that's primary to the City's medical plan? <b>YES NO</b>	Does your spouse have Medicare A Only, B Only or another RX Plan? <b>YES NO</b>
If Yes; Name of the Insured:	If Yes; Medicare A Effective Date:
Insurance Company Name:	Medicare B Effective Date:
Policy Number:	RX Effective Date:
Effective Date:	Medicare Claim Number:

Retiree /Surviving Spouse Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Spouse Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# RETIREE

**TO BE COMPLETED BY BENEFITS OFFICE:**

## VISION Plan Enrollment Form—CITY OF MEMPHIS

Effective Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Termination Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

### I. Check the Appropriate Boxes

#### Coverage Desired

#### EXAM/MATERIALS SEMI-MONTHLY RATES

Retiree Only \$2.18

Retiree + 1 \$4.00

Retiree + Family \$6.79

New Enrollment

Change of  
Status/Address

Open Enrollment

COBRA

Cancel Coverage

#### REASON FOR CHANGE IN STATUS

Termination

Marriage

Newborn Child

Other Insurance

Move to COBRA

Death

Divorce

Last Name/Address Change

Adoption/legal custody  
of child

Legal custody of  
parent

Dependent child married  
/reached age limit

### II. Employee Information (please print clearly):

Social Security Number \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Birth Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Your Name \_\_\_\_\_  
(First) (Middle Initial) (Last)

Address \_\_\_\_\_  
\_\_\_\_\_

Home Phone (\_\_\_\_) \_\_\_\_ - \_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_ - \_\_\_\_

### III. List All Eligible Family Members Below (if electing dependent coverage):

	First Name	Last Name	Birth Date	Social Security Number	Sex
Spouse	_____	_____	____/____/____	____-____-____	<input type="checkbox"/> M / <input type="checkbox"/> F
Child	_____	_____	____/____/____	____-____-____	<input type="checkbox"/> M / <input type="checkbox"/> F
Child	_____	_____	____/____/____	____-____-____	<input type="checkbox"/> M / <input type="checkbox"/> F
Child	_____	_____	____/____/____	____-____-____	<input type="checkbox"/> M / <input type="checkbox"/> F
Child	_____	_____	____/____/____	____-____-____	<input type="checkbox"/> M / <input type="checkbox"/> F

I agree to continue enrollment in the vision plan for a period of 12 month. I confirm that the information I have provided on this form is complete and accurate.

Retiree Signature \_\_\_\_\_ Date \_\_\_\_\_

**The Certificate of Coverage for Vision benefits is available online at <http://www.memphistn.gov/framework.aspx?page=167> or Refer to the City of Memphis Health, Wellness & Benefits Service Center located at 2714 Union Avenue Ext. 5<sup>th</sup> Floor Room 100.**

# RETIREE

**TO BE COMPLETED BY BENEFITS OFFICE:**

Effective Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Termination Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

## DENTAL Plan Enrollment Form—CITY OF MEMPHIS

### I. Check the Appropriate Boxes

*Semi-Monthly Rates*

#### Coverage Desired:

#### DPPO-PREMIER Dental Plan

- Retiree Only \$9.75  
 Retiree + 1 \$20.06  
 Retiree + Family \$29.19

#### DHMO-BASIC Dental Plan

- Retiree Only \$6.21  
 Retiree + 1 \$10.56  
 Retiree + Family \$16.87

New Enrollment

Change of Status/Address

Open Enrollment

COBRA

Cancel Coverage

#### REASON FOR CHANGE IN STATUS

Termination

Marriage

Newborn Child

Other Insurance

Move to COBRA

Death

Divorce

Last Name/Address Change

Adoption/legal custody of child

Legal custody of parent

Dependent child married/reached age limit

### II. Employee Information (please print clearly):

Social Security Number \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Birth Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Your Name \_\_\_\_\_  
(First) (Middle Initial) (Last)

Address \_\_\_\_\_  
\_\_\_\_\_

Home Phone (\_\_\_\_) \_\_\_\_ - \_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_ - \_\_\_\_

### III. List All Eligible Family Members Below (if electing dependent coverage):

	First Name	Last Name	Birth Date	Social Security Number	Sex
Spouse	_____	_____	____/____/____	____-____-____	<input type="checkbox"/> M / <input type="checkbox"/> F
Child	_____	_____	____/____/____	____-____-____	<input type="checkbox"/> M / <input type="checkbox"/> F
Child	_____	_____	____/____/____	____-____-____	<input type="checkbox"/> M / <input type="checkbox"/> F
Child	_____	_____	____/____/____	____-____-____	<input type="checkbox"/> M / <input type="checkbox"/> F
Child	_____	_____	____/____/____	____-____-____	<input type="checkbox"/> M / <input type="checkbox"/> F

I agree to continue enrollment in the vision plan for a period of 12 month. I confirm that the information I have provided on this form is complete and accurate.

Retiree Signature \_\_\_\_\_ Date \_\_\_\_\_

The Certificate of Coverage for Vision benefits is available online at <http://www.memphistn.gov/framework.aspx?page=167> or Refer to the City of Memphis Health, Wellness & Benefits Service Center located at 2714 Union Avenue Ext. 5<sup>th</sup> Floor Room 100.