



City of Memphis

RETIRED EMPLOYEE BENEFITS ENROLLMENT CHANGE FORM AND INSURANCE AFFIDAVIT

NOTE: Complete **ONLY** if you elect to enroll in or change existing coverage. All benefits will continue unless you make a change. When completing the form, if you fail to make a selection, we will assume you are waiving the coverage and will not enroll you nor your dependents for that benefit.

Retiree ACTION (please select one):

Enroll in Benefits Cancel All Benefits Make Changes Add/Delete Dependents

A. Retiree INFORMATION

Social Security Number - -	City Oracle ID Number	Last Name M.I.	First Name	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
Home Street Address	Apt.#	Effective Date of Enrollment/Change:	Division Name	
City, State, Zip	Date of Birth:			
Email Address:	Phone: <input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work () -			

B. REASON FOR ENROLLMENT/CHANGE

Check one Reason:

I am enrolling during Annual Enrollment

There has been a change in my family status (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 _____ (Qualifying Life Events: Birth/Adoption, Marriage, Divorce or Legal Separation, Change in spouses employment, death, etc.)

C. BENEFIT ELECTION (CHECK ONE PER BENEFIT)

Medical Plan	ENROLL: <input type="checkbox"/> BASIC <input type="checkbox"/> PREMIER <input type="checkbox"/> VALUE <input type="checkbox"/> CANCEL COVERAGE <input type="checkbox"/> NO CHANGE <input type="checkbox"/> WAIVE COVERAGE If waived, are you are covered by another plan. Yes or No If yes, please list name of insurance carrier _____	<input type="checkbox"/> RETIREE ONLY <input type="checkbox"/> RETIREE + FAMILY
Dental Plan	ENROLL: <input type="checkbox"/> BASIC <input type="checkbox"/> PREMIER <input type="checkbox"/> PRIMARY <input type="checkbox"/> WAIVE <input type="checkbox"/> CANCEL <input type="checkbox"/> NO CHANGE	<input type="checkbox"/> RETIREE ONLY <input type="checkbox"/> RETIREE + 1 <input type="checkbox"/> RETIREE + FAMILY
Vision Plan	ENROLL: <input type="checkbox"/> EXAM & MATERIALS <input type="checkbox"/> MATERIALS ONLY <input type="checkbox"/> WAIVE <input type="checkbox"/> CANCEL <input type="checkbox"/> NO CHANGE	<input type="checkbox"/> RETIREE ONLY <input type="checkbox"/> RETIREE + 1 <input type="checkbox"/> RETIREE + FAMILY

D. FAMILY MEMBERS TO BE COVERED - List all dependents to be covered. If you do not list a dependent, they will not be covered

LAST NAME	FIRST	M.I.	Social Security Number (Required)	Date Of Birth	Check desired Action			Employer Use Only:
					Medical	Dental	Vision	
Spouse:					<input type="checkbox"/> Enroll <input type="checkbox"/> Cancel	<input type="checkbox"/> Enroll <input type="checkbox"/> Cancel	<input type="checkbox"/> Enroll <input type="checkbox"/> Cancel	Effective Date:
Child:					<input type="checkbox"/> Enroll <input type="checkbox"/> Cancel	<input type="checkbox"/> Enroll <input type="checkbox"/> Cancel	<input type="checkbox"/> Enroll <input type="checkbox"/> Cancel	Effective Date:
Child:					<input type="checkbox"/> Enroll <input type="checkbox"/> Cancel	<input type="checkbox"/> Enroll <input type="checkbox"/> Cancel	<input type="checkbox"/> Enroll <input type="checkbox"/> Cancel	Effective Date:
Child:					<input type="checkbox"/> Enroll <input type="checkbox"/> Cancel	<input type="checkbox"/> Enroll <input type="checkbox"/> Cancel	<input type="checkbox"/> Enroll <input type="checkbox"/> Cancel	Effective Date:
Child:					<input type="checkbox"/> Enroll <input type="checkbox"/> Cancel	<input type="checkbox"/> Enroll <input type="checkbox"/> Cancel	<input type="checkbox"/> Enroll <input type="checkbox"/> Cancel	Effective Date:
Child:					<input type="checkbox"/> Enroll <input type="checkbox"/> Cancel	<input type="checkbox"/> Enroll <input type="checkbox"/> Cancel	<input type="checkbox"/> Enroll <input type="checkbox"/> Cancel	Effective Date:

E. OTHER INSURANCE COVERAGE INFORMATION (PLEASE COMPLETE THE SECTION BELOW)

<p>Do you or any of your covered dependents have other Medical/Medicare coverage that is primary to the City's Medical Plan? Yes or No If Yes, Name of Insured: _____ Place of Employment: _____ Insurance Company: _____ Policy #: _____ Insurance Company Phone #: _____ Insurance Company Address: _____</p>	<p>If covered by Medicare, please check what type(s): <input type="checkbox"/> Part A <input type="checkbox"/> Part B <input type="checkbox"/> Both A&B Reason for Medicare Entitlement: <input type="checkbox"/> Age <input type="checkbox"/> Disability <input type="checkbox"/> End Stage Renal Disease Medicare HIC #: _____ Medicare Part A Effective Date: _____ Medicare Part B Effective Date: _____</p>
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ACKNOWLEDGEMENT AND AUTHORIZATION:

I, _____, hereby certify under penalty of perjury that the information provided in this application for Retiree benefits, including social security numbers, addresses, spouse and or dependent child(ren) information, is true and correct. I further acknowledge that I understand that providing false information may subject me to a denial of Retiree benefits, disciplinary action including termination of employment from City of Memphis. I authorize the release of this information to my employer, the City of Memphis, and insurance carriers. In addition:

- I authorize my employer to reduce my salary by pre-tax or after-tax deductions, either prospectively or retroactively, for my elected benefits.
- I agree it is my responsibility to check my earnings statement each month to verify my current benefits enrollments and deductions and to alert Health Wellness and Benefits immediately of any errors. Further, I understand that the City of Memphis may not be able to remedy problems identified beyond 30 days.
- I understand that my benefits can only be changed during the designated annual Open Enrollment period or by written notification to Health Wellness and Benefits within 60 days of a qualified life event.
- I understand it is my responsibility to contact Health Wellness and Benefits within 60 days to remove my ex-spouse from all benefits plans if I divorce or become legally separated.
- I understand that while on an unpaid leave of absence or any unpaid status, I am responsible for paying my benefits premiums. Failure to pay premiums timely may result in cancellation of my benefits and reimbursement of any claims paid to my provider(s) for healthcare, etc.

My signature below indicates I have read and understand the above:

Print Name:	Signature:	Date:	Oracle Retiree ID #(Required):

EMPLOYER USE ONLY:

Retiree Enrollment Date:	Termination Date:	Employment Status: _Active _COBRA _ NEMP
		Received By/Date:
Received By/Date:	Entered By/Date:	



CITY OF MEMPHIS INSURANCE AFFIDAVIT

If you or a member of your family age 16 or older uses tobacco or nicotine products, you will have to pay the tobacco surcharge.

If your spouse has access to medical insurance through his/her employer but has declined coverage, you will pay the spouse surcharge if you choose to enroll him/her in the City of Memphis medical plan.

To determine if you will be subject to either or both surcharges per pay period, you must answer all of the following questions. Any questions left blank could result in the assessment of the surcharge(s):

- yes or no 1) Do you or your family members age 16 or over who are enrolled/enrolling in the medical plan use nicotine products including, but not limited to cigarettes, snuff, chewing tobacco, etc.?

If so, please list all family members who use tobacco/nicotine: _____, _____
_____, _____

- yes or no 2) Are you enrolling your spouse in medical? (If no, skip to signature section)

- yes or no a) Is your spouse employed?

- yes or no b) Does your spouse have medical insurance through his/her employer or is he/she enrolled in Medicare? (If your spouse has other insurance that is primary, the surcharge will not apply).

- yes or no c) Does your spouse have access to other medical insurance but chooses not to enroll? (If so, a spouse surcharge will be added to your medical premium.)

Please provide your spouse's name, spouse's employer name and telephone number:

Spouse Name: _____ Employer Name: _____

Employer Telephone Number: _____ Insurance Company Name: _____

Group Number: _____ Subscriber ID #: _____

By signing this affidavit, I am certifying that I have answered the questions regarding tobacco/nicotine usage and my spouse's access to medical coverage honestly and completely under the penalties of perjury. If I am found guilty of perjury, I will be held liable to repay all claims and the City of Memphis has the right to terminate my benefits as well as my employment.

Retiree Signature:	Retiree Oracle ID #:
Retiree Printed Name:	Date: