

# JANUARY 1, 2004 OPEN ENROLLMENT – RETIREE

## Benefits Election Form

<input type="checkbox"/> New <input type="checkbox"/> Change <input type="checkbox"/> Cancel   Date Effective – <b>January 1, 2004</b> If change, reason for Change <u>Open enrollment</u>						
Social Security Number		RIN (Employee Number)		Name: Last	First	MI
Street Address			City		State	Zip Code
Home Phone		Work Phone		Date of Birth		Retirement Date
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female						
Date of Hire		Email Address			Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widow(er)	

▪ Please select the plans and coverage levels that you would like to participate in.

Medical – Select One	Employee	Two Person	Family	None/Cancel
<input type="checkbox"/> The Rensselaer Health Plan (RHP)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Rensselaer HMO Plan (Former CDPHP)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Mohawk Valley Physician's Health Plan (MVP) Group #: 211419	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Dental – Only available for 18 months after date of retirement</b>				
<input type="checkbox"/> MetLife Group #: 2127444 Subcode: 001 Branch: 0002	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Enrollment Information	Coverage Under Medical/ Dental Y/N		Social Security Number	Gender M/F	Date of Birth	Primary Care Physician & OB/GYN Required for all plans	Current Patient Y/N	Disabled Y/N
	Medical	Dental						
<b>Name</b> Retiree								
Spouse								
Child								
Child								
Child								

<b>College Student Information</b>		Please complete if you are enrolling a child that is a full-time college student.		
Name of Child		Name of School		Anticipated Graduation Date
<b>Coordination of Benefits Information</b>		Are you, your spouse, or any children listed above covered by another health insurance plan? If yes:		
Name of Policyholder:		Policy#	Insurance Company	Effective Date
Covered Under Policy: <input type="checkbox"/> Self <input type="checkbox"/> Your Spouse <input type="checkbox"/> Your Children				
<b>Medicare/TEFRA Information</b>		Are you, your spouse, or any children listed above covered by Medicare? If Yes:		
Name of Policyholder		Medicare Number	Part A (Hospital) Effective Date	Part B (Medical) Effective Date

**Special Enrollment Rights:** If you are declining coverage in the Medical component of the plan for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll your spouse or your dependents in the plan, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption or placement for adoption. **Acceptance:** I hereby apply, on behalf of myself and each dependent listed above, for the coverage elected. I understand that coverage will be provided according to the terms and conditions of the contract between the insurance carrier(s) and my employer. I hereby authorize any physician, hospital or other provider of service to furnish any information, reports or copies of records, related to care or services rendered to me or any of the dependents listed above to the insurance carrier(s) or other third parties who require such information to administer the plan. Such information is to be held confidential. I understand that by completing and signing this enrollment form, I am making a binding election with regard to my benefits and that I am authorizing my employer to make the deductions necessary to pay my share of the cost of coverage. I further understand that I cannot cancel or change this election unless I experience a Change-in-Status or am entitled to a Special Enrollment Right. I also authorize subsequent payroll deductions in future plan years unless I notify my employer of a change in my election.

RETIREE Signature \_\_\_\_\_

Date \_\_\_\_\_