

# JANUARY 1, 2005 OPEN ENROLLMENT – RETIREE

## Benefits Election Form

<input type="checkbox"/> Change <input type="checkbox"/> Cancel		Date Effective – <b>1/1/2005</b>		If change, reason for Change <b>2005 Open Enrollment</b>	
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	
Date of Hire		Email Address		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	
				Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widow(er)	

- Please select the plan and coverage levels that you would like to participate in or change.

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 HMO)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Mohawk Valley Physician's Health Plan (MVP)	<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
Name	Medical	Dental						
Retiree								
Spouse								
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, you can **not** in the future be able to enroll you, your spouse and/or your dependents in the plan. 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. I further understand that I cannot elect to change this election until the following Open Enrollment Period unless I experience a Change-in-Status or am entitled to a Special Enrollment Right.

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