RETIREE ENROLLMENT FORM

Employee No. | | | | | | | |

Effective Date: _____

EMPLOYEE NAME:	EMAIL
ADDRESS:	ZIPCODE:
PHONE:	SOCIAL SECURITY #:
MEDICARE #:	MEDICARE B EFFECTIVE DATE:

MEDICAL/DENTAL PLANS:

NON-MEDICARE (MEDICAL, VISION, PRESCRIPTION DRUGS)	DENTAL	TRADITIONAL MEDICARE WITH MEDICAL/VISION/PRESCRIPTION DRUGS PLANS (MUST BE ENROLLED IN MEDICARE PARTS A AND B AND PROVIDE A COPY OF MEDICARE CARD)	MEDICARE Advantage Plans w/Part D MEDICAL/VISION/PRESCRIPTION DRUGS (MUST BE ENROLLED IN MEDICARE PARTS A AND B ONLY AND PROVIDE A COPY OF MEDICARE CARD)
Kaiser Permanente HMO and NVA Vision ☐ SINGLE COVERAGE ☐ FAMILY COVERAGE	Dental Coverage ☐ SINGLE COVERAGE ☐ FAMILY COVERAGE ☐ BOTH RETIRED 689 MEMBERS	Kaiser Medicare Plan and NVA Vision Single Coverage ☐ SINGLE COVERAGE ☐ FAMILY + 1 (ONE PERSON IN MEDICARE) ☐ FAMILY + 2 (TWO PEOPLE IN MEDICARE)	Kaiser Medicare Advantage Plan w/Part D and NVA Vision ☐ SINGLE COVERAGE ☐ FAMILY + 1 (ONE PERSON IN MEDICARE) ☐ FAMILY + 2 (TWO PEOPLE IN MEDICARE)
Blue Choice HMO and Davis Vision ☐ SINGLE COVERAGE ☐ FAMILY COVERAGE	Dental Plans ☐ CAREFIRST DENTAL ☐ CAREFIRST DENTAL WITH ORTHO ☐ CIGNA DENTAL DHMO	Blue Choice Medical HMO and Davis Vision ☐ SINGLE COVERAGE ☐ FAMILY + 1 (ONE PERSON IN MEDICARE) ☐ FAMILY + 2 (TWO PEOPLE IN MEDICARE)	BlueCross BlueShield Medicare Advantage Plan w/Part D PPO ☐ SINGLE COVERAGE ☐ TWO PARTY COVERAGE (BOTH 65+)
CareFirst BC Advantage PPO and Davis Vision ☐ SINGLE COVERAGE ☐ FAMILY COVERAGE	VOLUNTARY BENEFITS Spousal Credit *Form is available at TEHW Office or online at tehw.org/member-resources/forms-and-documents/*	CareFirst Blue Choice PPO and David Vision ☐ SINGLE COVERAGE ☐ FAMILY + 1 (ONE PERSON IN MEDICARE) ☐ FAMILY + 2 (TWO PEOPLE IN MEDICARE)	MAPD BlueChoice Medical HMO and Davis Vision ☐ FAMILY + 1 (ONE PERSON IN MEDICARE) ☐ FAMILY + 2 (TWO PEOPLE IN MEDICARE)
	Opt-Out *Form is available at TEHW Office or online at tehw.org/member-resources/forms-and-documents/*		MAPD CareFirst BlueChoice Advantage PPO and Davis Vision ☐ FAMILY + 1 (ONE PERSON IN MEDICARE) ☐ FAMILY + 2 (TWO PEOPLE IN MEDICARE)

Signature: _____ **Date:** _____

ADD/REMOVE DEPENDENTS:

SPOUSE NAME:	☐ ADD ☐ REMOVE
ADDRESS:	DATE OF BIRTH:
PHONE:	ZIPCODE:
MEDICARE A#:	EFFECTIVE DATE:
MEDICARE B#:	EFFECTIVE DATE:

CHILD NAME:	☐ ADD ☐ REMOVE
ADDRESS:	DATE OF BIRTH:
PHONE:	ZIPCODE:

CHILD NAME:	☐ ADD ☐ REMOVE
ADDRESS:	DATE OF BIRTH:
PHONE:	ZIPCODE:

CHILD NAME:	☐ ADD ☐ REMOVE
ADDRESS:	DATE OF BIRTH:
PHONE:	ZIPCODE:

CHILD NAME:	☐ ADD ☐ REMOVE
ADDRESS:	DATE OF BIRTH:
PHONE:	ZIPCODE: