2018 Retiree Benefit Election

Effective Date ____/____/____ Retirement Date ____/____/____

☐ Retirement ☐ Open Enrollment ☐ Change

Retiree Name _____ Retiree SSN ___-___-____
(Print) Last First Middle Initial

Spouse Name _____ Spouse SSN ___-___-____
(Print) Last First Middle Initial

Home Address _____
Street City State ZIP Code

Phone (___) ___-_____ E-mail Address: _____

Retiree: Medicare Eligible? ☐YES ☐NO
Spouse: Medicare Eligible? ☐YES ☐NO

If YES, enrolled retiree/spouse may continue coverage by selecting the Retiree First Medicare Supplement Plan and Prescription Plan. Retiree/spouse must also be enrolled in Medicare Part A and Part B.

Qualifying Event Change: ☐Add Dependent ☐Cancel Dependent ☐Cancel Retiree
Reason: ☐Marriage/Divorce ☐Loss of Other Coverage ☐Gain of Other Coverage ☐Medicare Eligible ☐Other: _____

MEDICAL INSURANCE					
☐Waive Medical ☐No Change	Retiree Only	Spouse Only	Retiree +Spouse	Retiree +Child(ren)	Retiree +Family
EPO Plan (Pre-Medicare Eligible)	☐	☐	☐	☐	☐
Retiree First Medicare Supplement Plan & Prescription Plan (Medicare Eligible)*	☐	☐			

**The EPO plan will terminate effective the date the retiree or spouse is Medicare eligible. The retiree may elect to continue coverage for the retiree or spouse through the supplemental plan. Contact Retiree First at (719) 249-7788 or (855) 531-8844 for more information.*

DENTAL INSURANCE (check one box only)					
☐Waive Dental ☐No Change	Retiree Only	Spouse Only	Retiree +Spouse	Retiree +Child(ren)	Retiree +Family
Dental Low Option Plan	☐	☐	☐	☐	☐
Dental High Option Plan	☐	☐	☐	☐	☐

VISION INSURANCE (check one box only)					
☐Waive Vision ☐No Change	Retiree Only	Spouse Only	Retiree +Spouse	Retiree +Child(ren)	Retiree +Family
Vision Plan	☐	☐	☐	☐	☐

PLEASE COMPLETE THE FOLLOWING INFORMATION FOR THE PLANS SELECTED ABOVE.

Name Last First M.I.	Medical	Dental	Vision	Social Security Number	Sex M/F	Birth Date mm/dd/yyyy
Retiree	☐	☐	☐	___-___-		/ /
Spouse	☐	☐	☐	___-___-		/ /
Dependent Child	☐	☐	☐	___-___-		/ /
Dependent Child	☐	☐	☐	___-___-		/ /

If I do not elect to continue a benefit at the time of retirement, the benefit is forfeited for me and my dependents. I acknowledge that my signature authorizes the release of the purchased service time information to El Paso County Employee Benefits Division. I have read and understand my benefit choices available and elect the options checked above and understand that changes cannot be made unless I experience a qualifying life event. I understand that it is my responsibility to notify El Paso County Employee Benefits Division in writing, within 31days; of any changes in the eligibility of my dependents and that the Plan is not responsible for informing me of all my rights, benefits and services under the selected healthcare provider. I also understand that late or non-payment of health premiums will result in termination of coverage retroactive to the last day coverage was paid in full.

Retiree Signature: _____ Date: ____/____/____ Employee Benefits Division Approved: _____

Retirement Office Use Only

Service Time: _____ Purchased Time: _____ Total Creditable Time: _____

White: Employee Benefits Division Yellow: Retirement Pink: Retiree

Rev. October 2017