# City of Houston
# Cigna-HealthSpring Preferred with Rx (HMO)
# Retiree Election Form

Complete this form if you elect to join the ***Cigna-HealthSpring Preferred with Rx (HMO)*** plan.
This form must be sent along with the City of Houston Medicare plan election form to the address below.
You must have Medicare Parts A and B to enroll in this plan.

☐ I elect the ***Cigna-HealthSpring Preferred with Rx (HMO)*** plan.

| | | | |
|---|---|---|---|
| Last name (include surname: Jr., Sr., etc.): First name: Middle initial:<br>Name must match Medicare health insurance card | | | ☐ Mr. ☐ Mrs. ☐ Ms. |
| Birth date:<br>___ ___/___ ___/___ ___ ___ ___<br>M M D D Y Y Y Y | Gender:<br>☐ M<br>☐ F | Telephone:<br>( ) - | Social Security number:<br>___ ___ ___/___ ___/___ ___ ___ ___ |
| Medicare Claim Number:<br>___ ___ ___-___ ___-___ ___ ___ ___ ___ | | Hospital Part A effective date:<br>Medical Part B effective date: | |
| Permanent residence street address (P.O. box is not allowed): | | | |
| City: | State: | ZIP code: | County: |
| Mailing address (only if different from your permanent residence address): | | | |
| City: | State: | ZIP code: | County: |
| Email address: | | | |
| Emergency contact: | Phone number: | Relationship to you: | |
| Primary Care Physician name: | | Primary Care Physician ID#: | |

Enrollee's signature: _____ Date: _____

**Please return to:**
City of Houston
Benefits Division
P.O. Box 248
Houston, TX 77001
Phone: 888-205-9266 or