City of Houston
RETIREE/SURVIVOR
MEDICARE PLANS MEDICAL/DENTAL/VISION ELECTION FORM

FOR BENEFITS DIVISION ONLY				
Department:	**Retirement Date:**	**Medical Effective Date:**	**Dental Effective Date:**	**Vision Effective Date:**

PRINT OR TYPE WITH BLUE OR BLACK INK ONLY

PENSION SYSTEM	SOCIAL SECURITY NO.	SEX	EMPLOYEE ID#
☐ Municipal ☐ Fire ☐ Police		☐ Male ☐ Female	

Print **Retiree Last Name**	Print **Retiree First Name**	M I

Address:	Apt. No.	City	State	Zip Code

A. Complete the following for each person to be covered under a Medicare Plan. Select a plan for each person. Request an application from the plan you elect. If a covered person does not have Medicare Parts A & B, please complete Section B to continue their coverage in a Cigna health plan. Persons with ESRD may enroll in a Cigna, Aetna ESA PPO or Supplement F plan.

Plan	Last Name	First Name	Social Security No.	Date of Birth	Relationship
AETNA ESA PPO					SELF
					SPOUSE
KELSEYCARE ADVANTAGE HMO					SELF
					SPOUSE
CIGNA HEALTHSPRING HMO					SELF
					SPOUSE
TEXANPLUS HMO					SELF
					SPOUSE
AARP MEDICARE SUPPLEMENT PLAN F AND UNITED HEALTHCARE MEDICARE PART D RX PLAN					SELF
					SPOUSE

Select a Cigna plan for your eligible dependents:

☐ Cigna Limited Network Plan:
Cigna KelseyCare
Renaissance IPA
Mayor Healthcare Group
Memorial Hermann

Medical Coverage Type:
☐ Retiree/Survivor Only
☐ Retiree + Spouse
☐ Retiree/Survivor + Child(ren)
☐ Retiree + Spouse + Child(ren)

(Name a Primary Care Physician in Section C)

☐ Cigna Open Access
☐ Consumer Driven Health Plan
☐ Retirees of Texas Option Plus (Must live outside the Limited Network Services Area but in Texas.)

☐ I OPT-OUT OF MEDICAL COVERAGE: I understand that I may re-enroll in the future.

Dental Plan – Policy# 709643 (select one):
☐ Indemnity Plan – PVRC – 0001
☐ DHMO Plan – PVRC – 0013

Dental Coverage Type:
☐ Retiree/Survivor Only
☐ Retiree/Survivor + 1 Dependent
☐ Retiree/Survivor + 2 or More Dependents

BLOCK VISION
Vision Coverage Type:
☐ Retiree/Survivor Only
☐ Retiree + Spouse
☐ Retiree/Survivor + Child(ren)
☐ Retiree + Spouse + Child(ren)

☐ I OPT-OUT OF VISION COVERAGE:
I understand that I may re-enroll in the future.

☐ I OPT-OUT OF DENTAL COVERAGE: I understand that I may re-enroll in the future.

B. Complete the following for each person that will be covered under the plan you selected. — **$25 Monthly Charge for Tobacco Users**

Last Name First Name MI	Medical Add/Drop	Dental Add/Drop	Vision Add/Drop	Social Security No.	Date of Birth	Relationship (Circle One)	Tobacco User (Yes / No)
						SELF	Yes / No
						SPOUSE	Yes / No
						SON / DAUGHTER	Yes / No
						SON / DAUGHTER	Yes / No

C. Complete this section to show your Cigna KelseyCare ID of #8877698011, or Renaissance, or Mayor Healthcare Group Primary Care Physician (PCP) and DHMO Dentist ID numbers, as required for person(s) in Section B.

Person (Circle One)	Male ✓	Female ✓	Last Name, First, M.I.	Primary Care Physician No.	DHMO Dentist ID #
Retiree					
Husband/Wife					
Child/Stepchild/Grandchild					
Child/Stepchild/Grandchild					
Child/Stepchild/Grandchild					

NOTE: An Eligible Dependent means your legal spouse, and any child (natural, adopted, foster, grandchild, stepchild, a child for whom you are legal guardian and/or have legal support obligations) who is your dependent for federal income tax purposes, resides with you (except in the case of a court order), and is under age 26. A dependent may be your child who is 26 or older, primarily supported by you, and incapable of self-sustaining employment by reason of mental, physical disability or handicap which arose while the child was covered as a dependent under this Plan, or while covered as a dependent under a prior City plan without a break in coverage. Proof of the child's condition and dependence must be submitted within 31 days after the child ceases to qualify.

Relationship documents: certified marriage certificate, Registration and Declaration of an Informal Marriage certificate (common law), legal and court order documents, and official birth certificates or birth fact, as appropriate.

D. Authorization of Deductions From Pension Check

I am a retiree or survivor of the City of Houston, eligible to participate in the Health Benefits Program. I apply to make the above coverage election and understand that information I have provided is part of my application. All statements made by me may be relied upon by the City; if any information that I have provided is found to be materially incorrect, my coverage may be denied. I realize that coverage my dependents are eligible for at this time, which I drop, may not be available until the next open enrollment, unless I provide proof of a change in family status within 31 days of the family status change. I agree that if I have listed ineligible dependents, I may incur a monetary penalty and /or my medical coverage may be canceled. If I waive coverage for which I or my dependents are eligible, I will not be eligible for coverage in the future. I authorize the pension system to deduct from my pension check my portion of the contribution as it becomes due.

I understand that I must notify the City of Houston when I have an ineligible dependent and that I may not receive a refund of contributions paid for an ineligible dependent. I will be responsible for medical claims paid on an ineligible dependent. All plan provisions will apply to my dependents.

Date	Contact Phone Number	Signature