# City of Houston Benefits RETIREE/SURVIVOR Medical/Dental/Vision Form

P.O. Box 248, Houston, TX 77002-0248 | 832-393-6000 | 832-395-9409
retireebenefits@houstontx.gov | cityofhoustonbenefits.org

**Print or type with blue or black ink only**

| Employee ID | Pension System | Social Security Number | Gender |
|---|---|---|---|
| | ☐ Municipal ☐ Fire ☐ Police | | ☐ Male ☐ Female |

| First Name | Last Name | M.I. | Contact Number |
|---|---|---|---|
| | | | |

| Address (Check box if address change) ☐ | Apt. No. | City | State | Zip |
|---|---|---|---|---|
| | | | | |

**A. Group Benefits Choice:** Complete for all applicable.

Note: The City's five Medicare Plans are available to Retirees/Dependents who are Medicare eligible and covered under Medicare Parts A & B. The Cigna plans are not available to Medicare-eligible Retirees and their Medicare-eligible Dependents.

**Medical Plans (select one):**

- ☐ Cigna Limited Network Plan (select a network)
  - ☐ Cigna KelseyCare
  - ☐ Memorial Hermann
  - ☐ Renaissance

  Physican ID or name _____
- ☐ Cigna Open Access Plan
- ☐ Cigna Consumer-Driven Health Plan

**Medical Coverage Tier (select one):**

- ☐ Retiree/Survivor Only
- ☐ Retiree + Spouse
- ☐ Retiree + Child(ren)
- ☐ Retiree + Family

**Dental Plans (select one):**

- ☐ DHMO Plan
- ☐ DPPO Plan

**Dental Coverage Tier (select one):**

- ☐ Retiree/Survivor Only
- ☐ Retiree + 1
- ☐ Retiree + 2 or more

**Vision Coverage Tier (select one):**

- ☐ Retiree/Survivor Only
- ☐ Retiree + Spouse
- ☐ Retiree + Child(ren)
- ☐ Retiree + Family

**Opt Out:** I understand that I may re-enroll in the future during Open Enrollment, or if I have a Qualifying Life Event.

☐ Medical ☐ Dental ☐ Vision

**B. Dependents:** Complete for yourself and your eligible dependent(s).

| Relationship | Last Name, First Name, M.I. | Gender (M or F) | Medical (add or drop) | Dental (add or drop) | Vision (add or drop) | Date of Birth | Social Security No. | Tobacco User* |
|---|---|---|---|---|---|---|---|---|
| Self/Retiree | | | | | | | | ☐ |
| | | | | | | | | ☐ |
| | | | | | | | | ☐ |
| | | | | | | | | ☐ |
| | | | | | | | | ☐ |

**Note: Eligible Dependent** - An eligible dependent is your legal spouse and any child (natural, adopted, foster, grandchild, stepchild, and a child for whom you are legal guardian and/or have legal support obligation) who is your dependent for federal income tax purposes, resides with you, and is under age 26 or under age 25 for grandchild(ren).

**Disabled Children age 26 and over -** Child must be primarily supported by you, and incapable of self-sustaining employment by reason of mental incapacity, physical disability or handicap, which arose while the child was covered as a dependent on a City plan without a break in coverage. Upon applying and receiving third party medical administrator's approval, proof of the child's condition and dependence must be submitted within 31 days or the child ceases to qualify for benefits.

**Relationship Documents -** Social Security Cards, Certified Marriage Certificate, Registration and Declaration of an Informal Marriage Certificate (common law), Legal and Court Order Documents, and Official Birth Certificates or Birth Facts.

***Non-tobacco User Discount -** If you and/or your dependents do not use tobacco products, you qualify for the monthly non-tobacco user discount of $35 per non-tobacco user. If you and/or any of your dependents indicated tobacco use, you will not be eligible for the non-tobacco user discount. By enrolling and participating in a smoking/tobacco cessation program, you may become eligible for the monthly non-tobacco user discount of $35 per participant. In order to be eligible for the discount, previously indicated tobacco users on the medical plan must participate in a smoking cessation program. Smoking/tobacco cessation programs must be facilitated or validated by the City of Houston.

**Important -** If both you and your spouse work(ed) for the City, you may be covered as an employee/retiree or as a dependent - but not both. Dependents may be enrolled under only one parent or guardian.

**C. Authorizations**

I am a retiree or survivor of the City of Houston, eligible to participate in the Medical, Vision, and Dental programs. 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. Once the enrollment deadline has past, my plan elections are binding until the next Open Enrollment period, however, I may opt out of the plan at any time. Completed enrollment forms and documentation of qualifying life events are required within 31 days of the event. Supporting documents for newly-added dependents are required within the 31 day time period of the life changing event. If documents are not received within the 31 days of the life changing event coverage will not be active for newly-added dependents. Therefore, newly-added dependents coverage will be delayed until next open enrollment or a qualifying life event.

I agree that if I acquire other coverage outside of the City of Houston Medical, Dental and Vision plans or if I have listed ineligible dependents, I may incur a monetary penalty and/or my coverage will be canceled. I understand that I must notify the City when I acquire other coverage outside of the City's plans and when I have an ineligible dependent. Contributions are paid one month in advance. If you opt out or make a plan or tier change at the end of the month, you may be eligible for a refund for contributions already paid.

I authorize the Pension System to deduct from my pension check my portion of the contribution as it becomes due.

I authorize any Medical, Vision or Dental Provider to disclose to the Plan Administrator(s) information relating to individuals specified on this application.

| Date | Contact Number | Signature |
|---|---|---|
| | | |

**For Benefits Use Only**

| Department | Retirement Date | Effective Date |
|---|---|---|
| | | |