City of Houston Benefits Medicare Eligible Retiree/Survivor Universal Enrollment Form

611 Walker, 4th Floor, TX 77002 | 832-393-6000 |
retireebenefits@houstontx.gov | cityofhoustonbenefits.org

Submit completed form to the Secure Document Portal at houstontx.gov/hr/benefits/sdsubmission_form.html

Print or type with blue or black ink only

Employee ID	Pension System	Contact Number	Gender
	☐ Municipal ☐ Fire ☐ Police		☐ Male ☐ Female

First Name	Last Name	M.I.

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

Please check the boxes if you would prefer us to send you information in: ☐ Spanish ☐ Braille/Large Print

A. Complete the following for each person to be covered under a City Medicare Advantage Plan. Select a plan for yourself and each eligible dependent. If a covered person does not have Medicare Parts A & B, please complete Section F of this form to continue their coverage in an Active Employee health plan.

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

Medicare Advantage Plans (select one):
- ☐ Aetna Basic PPO
- ☐ Aetna Premiere ESA PPO
- ☐ KelseyCare Advantage HMO

Medical Coverage Tier (select one):
- ☐ Retiree/Survivor Only
- ☐ Retiree/Survivor + Spouse
- ☐ Retiree/Survivor + Child(ren)
- ☐ Retiree/Survivor + Family

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								☐
								☐
								☐
								☐
								☐

B. Medicare Information - Retiree

Please refer to your red, white and blue Medicare card to complete this section.

- Fill out this information as it appears on your Medicare card.

OR

- Attach a copy of your Medicare card or your letter from the Social Security Administration.

Name (as it appears on your Medicare card): _____

Medicare Number: _____

Is entitled to: Effective Date:

HOSPITAL (Part A) _____

MEDICAL (Part B) _____

You must have Medicare Part A and Part B to join a City of Houston Medicare Advantage plan.

Initials _____

C. Medicare-Related Questions - Retiree	
☐ Yes ☐ No	**Do you or your spouse work?**
☐ Yes ☐ No	**Did you become eligible for Medicare because of ESRD and has it been less than 30 months since you became eligible?** If so, Medicare Advantage will be your secondary coverage for the first 30 months of the coordination period. If yes, provide your prior commercial coverage carrier's name: _____ Member number: _____ Effective Date: _____
☐ Yes ☐ No	**Was your previous policy terminated?** If yes, provide termination date: _____
☐ Yes ☐ No	**Are you enrolled in your state Medicaid program?** If Yes, provide your Medicaid number: _____ If Yes, will Medicaid pay your premiums for your selected Medicare Advantage policy? ☐ Yes ☐ No Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium? ☐ Yes ☐ No
☐ Yes ☐ No	**Will you have other prescription drug coverage in addition to your above selected Medicare Advantage plan?** If Yes, please list your other coverage and your identification (ID) number(s) for this coverage: Name of other coverage: _____ ID#: _____Group #: _____

D. Medicare Information - Dependent	
Please refer to your red, white and blue Medicare card to complete this section. • Fill out this information as it appears on your Medicare card. OR • Attach a copy of your Medicare card or your letter from the Social Security Administration.	Name (as it appears on your Medicare card): _____ Medicare Number: _____ Is entitled to: Effective Date: HOSPITAL (Part A) _____ MEDICAL (Part B) _____ You must have Medicare Part A and Part B to join a City of Houston Medicare Advantage plan.

E. Medicare-Related Questions - Dependent	
☐ Yes ☐ No	**Do you or your spouse work?**
☐ Yes ☐ No	**Did you become eligible for Medicare because of ESRD and has it been less than 30 months since you became eligible?** If so, Medicare Advantage will be your secondary coverage for the first 30 months of the coordination period. If yes, provide your prior commercial coverage carrier's name: _____ Member number: _____ Effective Date: _____
☐ Yes ☐ No	**Was your previous policy terminated?** If yes, provide termination date: _____
☐ Yes ☐ No	**Are you enrolled in your state Medicaid program?** If Yes, provide your Medicaid number: _____ If Yes, will Medicaid pay your premiums for your selected Medicare Advantage policy? ☐ Yes ☐ No Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium? ☐ Yes ☐ No
☐ Yes ☐ No	**Will you have other prescription drug coverage in addition to your above selected Medicare Advantage plan?** If Yes, please list your other coverage and your identification (ID) number(s) for this coverage: Name of other coverage: _____ ID#: _____Group #: _____

Initials _____

F. Disclosures

KelseyCare Advantage Plan

By completing this enrollment application, I agree to the following:

- I must keep both Hospital (Part A) and Medical (Part B) to stay enrolled in KelseyCare Advantage.
- By joining this Medicare Advantage Plan, I acknowledge that KelseyCare Advantage will share my information with Medicare, who may use it to track my enrollment, to make payments, and for other purposes allowed by Federal law that authorize the collection of this information (see Privacy Act Statement below).
- Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.
- The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.
- I understand that people with Medicare are generally not covered under Medicare while out of the country, except for limited coverage near the U.S. border.
- I understand that when my KelseyCare Advantage coverage begins, I must get all of my medical and prescription drug benefits from KelseyCare Advantage network providers. Benefits and services provided by KelseyCare Advantage and contained in my KelseyCare Advantage "Evidence of Coverage" document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor KelseyCare Advantage will pay for benefits or services that are not covered.
- II understand that my signature or initials (or the signature of the person legally authorized to act on my behalf) on this application means that I have read and understand the contents of this application. If signed by an authorized representative (as described above), this signature certifies that:
    1. This person is authorized under State law to complete this enrollment, and
    2. Documentation of this authority is available upon request by Medicare.

***Paying your Late Enrollment Penalty (LEP) If you owe a late enrollment penalty**, you can pay your penalty that you currently have or may owe by mail, Electronic Funds Transfer (EFT), credit card each month. **You can also choose to pay your premium by having it automatically taken out of your Social Security or Railroad Retirement Board (RRB) benefit each month. If you have to pay a Part D-Income Related Monthly Adjustment Amount (Part D-IRMAA), you must pay this extra amount in addition to your plan premium.** The amount is usually taken out of your Social Security benefit, or you may get a bill from Medicare (or the RRB). DON'T pay KelseyCare Advantage the Part D-IRMAA.*

Aetna Basic and Premiere Plans

By completing this enrollment application, I agree to the following: Aetna Medicare is a PDP, HMO, PPO plan with a Medicare contract. Enrollment in our plans depends on contract renewal. I will need to keep my Medicare Parts A and B coverage. I can only be in one Medicare Advantage plan at a time and I understand that my enrollment in this plan will automatically end my enrollment in another Medicare health plan. It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future. If I'm enrolling in a Medicare Advantage plan without prescription drug coverage (medical benefits only), I understand that if I don't have Medicare prescription drug coverage, or creditable prescription drug coverage (as good as Medicare's), I may have to pay a late enrollment penalty if I enroll in Medicare prescription drug coverage in the future. Enrollment in this plan is generally for the entire year. Once I enroll, I may leave this plan or make changes only at certain times of the year if an enrollment period is available or under certain special circumstances. The Aetna Medicare Advantage plan serves a specific service area. If I move out of the area that Aetna Medicare Advantage plan serves, I need to notify the plan and my former employer/union/trust so I can disenroll and find a new plan in my new area. Once I'm a member of the Aetna Medicare Advantage plan, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from Aetna when I get it to know which rules I must follow to get coverage with this Medicare Advantage plan. I understand that people with Medicare aren't usually covered under Medicare while out of the country except for limited coverage near the U.S. border. I may also be disenrolled if I do not pay any applicable plan premiums within the grace period. The effective date of disenrollment is in accordance with federal requirements. HMO plans - I understand that beginning on the date Aetna Medicare Advantage plan coverage begins, I must get all my health care from the Aetna Medicare Advantage plan, except for emergency or urgently needed services or out of area dialysis services. Services authorized by the Aetna Medicare Advantage plan and other services contained in my Aetna Medicare Advantage plan Evidence of Coverage document (also known as the member contract or subscriber agreement) will be covered. Without authorization, NEITHER MEDICARE NOR THE AETNA MEDICARE ADVANTAGE PLAN WILL PAY FOR THE SERVICES. PPO plans: I understand that beginning on the date Aetna Medicare Advantage plan coverage begins, using services in network can cost less than using services out of network, except for emergency or urgently needed services or out-of-area dialysis services. I understand I can go to doctors, specialists or hospitals in or out of network. I understand that providers must be licensed and eligible to receive payment under the federal Medicare program and agree to accept the PPO plan. I also understand I may have to pay more for services I receive out of network. Services authorized by the Aetna Medicare Advantage plan and other services contained in my Aetna Medicare Advantage plan Evidence of Coverage document (also known as the member contract or subscriber agreement) will be covered. Without authorization when required by the plan, NEITHER MEDICARE NOR THE AETNA MEDICARE ADVANTAGE PLAN WILL PAY FOR THE SERVICES. I've been advised not to cancel or drop any supplemental insurance I currently have until I receive written notification of my confirmed effective date from Aetna. I understand the providers in the Aetna network are independent contractors in private practice and are neither employees nor agents of Aetna or its affiliates. I understand if I'm getting assistance from a sales agent, broker, or other individual employed by or contracted with Aetna's Medicare Advantage plans, he/she may be paid based on my enrollment in the Aetna Medicare Advantage plan. Release of information: By joining this Medicare health plan, I acknowledge that the Medicare health plan will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that Aetna Medicare will release my information, including my prescription drug event data to Medicare, who may release it for research and other purposes which follow all applicable Federal statutes and regulations. The information on this enrollment form is correct to the best of my knowledge. I understand if I intentionally provide false information on this form, I will be disenrolled from the plan. I understand my signature (or the signature of the person authorized to act on my behalf under the laws of the state where I live) on this application means I have read and understand the contents of this application. If signed by an authorized individual (as described above), this signature certifies that: 1) this person is authorized under State law to complete this enrollment and 2) documentation of this authority is available upon request from Medicare.

Initials _____

G. Non-Medicare Eligible Medical Plans (select one)
If a covered person does not have Medicare Parts A & B, please complete the following to continue their coverage in an Active Employee health plan.

☐ Consumer-Driven Health Plan	☐ Cigna Limited Network Plan ☐ Kelsey-Seybold ☐ Village Family Practice ☐ Renaissance	☐ Cigna Open Access

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: 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 age 26 or older, primarily supported by you, and incapable of self-sustaining employment by reason of mental or 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/children ceases to qualify.

*Non-Tobacco User Discount – If you and/or your dependent(s) 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 dependent(s) are indicated above as a tobacco user, 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 any of the City of Houston's medical plans must participate in a smoking cessation program. Smoking/tobacco cessation programs must be facilitated or validated by the City of Houston.

H. Vision and Dental Plans Complete the following for each person to be covered under a City Dental and/or Vision Plan. Select a plan for yourself and each eligible dependent. You may only select these plans if you enrolled at time of retirement.

Dental Plans (select one):
- ☐ DHMO
- ☐ DPPO

Dental Coverage Tier (select one):
- ☐ Retiree/Survivor Only
- ☐ Retiree + 1 Dependent
- ☐ Retiree + 2 or more Dependents

Vision Coverage Tier (select one):
- ☐ Retiree/Survivor Only
- ☐ Retiree/Survivor + Spouse
- ☐ Retiree/Survivor + Child(ren)
- ☐ Retiree /Survivor+ Family

I. City of Houston Authorizations

This document reflects information as of the date listed herein. There is no promise, guarantee, or vested right to access health care coverage or a premium allowance. To the extent allowed by law or an agreement between the City of Houston and an employee association recognized as the exclusive bargaining agent for covered employees, the City of Houston has the discretion to amend, suspend, or terminate the health care plan at any time.

I am a retiree or survivor of the City of Houston, eligible to participate in the City of Houston Medicare Advantage Plan. I apply to make the above coverage election(s) and understand the information I have provided is part of my application. All statements made by me may be relied upon by the City of Houston; if any information that I have provided is found to be materially incorrect, my coverage may be denied. I understand that if both I and my spouse work(ed) for the City of Houston, I may be covered as an employee/retiree or as a dependent, but not both. Dependent(s) may be enrolled under only one parent or guardian.

I agree that if I acquire other coverage outside of the City of Houston, or if I have listed ineligible dependents, I may incur a monetary penalty and/or my coverage may 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 will be eligible for a refund for contributions already paid.

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

I authorize any Medicare Advantage Plan Provider to disclose to the Plan Administrator(s) information relating to individuals specified on this application.

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

Date	Contact Number	Signature