



City of Houston Medicare Eligible Retiree/Survivor Enrollment Form

📍 611 Walker, 4th Floor, Houston, TX 77002 | ☎ 832-393-6000 | 📠 832-395-9409

✉ retireebenefits@houston.tx.gov | 🌐 cityofhoustonbenefits.org

Print of type with blue or black ink only									
Employee ID	Pension System <input type="checkbox"/> Municipal <input type="checkbox"/> Police <input type="checkbox"/> Fire			Social Security Number		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female			
First Name			Last Name		M.I.	Contact Number			
Address (Check box if address change) <input type="checkbox"/>			Apt. No.	City		State	Zip		
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 B of this form to continue their coverage in a Cigna health plan. Persons with End Stage Renal Disease (ESRD) may not enroll in a City of Houston Medicare Advantage HMO plan.									
Medicare Advantage Plans: <input type="checkbox"/> Cigna HealthSpring HMO · HMO PCP Name: _____ <input type="checkbox"/> WellCare TexanPlus HMO · HMO PCP Name: _____ <input type="checkbox"/> KelseyCare Advantage HMO <input type="checkbox"/> Aetna Steerage PPO <input type="checkbox"/> Medicare Supplement Plan F			Dental Plans (select one): <input type="checkbox"/> DHMO Plan <input type="checkbox"/> DPPO Plan Dental Coverage Tier (select one): <input type="checkbox"/> Retiree/Survivor Only <input type="checkbox"/> Retiree + 1 Dependent <input type="checkbox"/> Retiree + 2 or more dependents			Vision Coverage Tier (select one): <input type="checkbox"/> Retiree/Survivor Only <input type="checkbox"/> Retiree/Survivor + Spouse <input type="checkbox"/> Retiree/Survivor + Child(ren) <input type="checkbox"/> Retiree/Survivor + Family			
Coverage Tier (select one): <input type="checkbox"/> Retiree/Survivor Only <input type="checkbox"/> Retiree/Survivor + Spouse <input type="checkbox"/> Retiree/Survivor + Child(ren) <input type="checkbox"/> Retiree/Survivor + Family			Opt-Out: I understand that I may re-enroll in the future at Open Enrollment, or if I experience a Qualifying Life Event. <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision						
Relationship	Last Name, First Name, M.I.		Gender	Medicare (Add/Drop)	Dental (Add/Drop)	Vision (Add/Drop)	Date of Birth	Social Security No.	Tobacco User*
Self/Retiree									<input type="checkbox"/>
									<input type="checkbox"/>
									<input type="checkbox"/>
									<input type="checkbox"/>
									<input type="checkbox"/>
B. Non-Medicare Eligible Medical Plans (select one)									
<input type="checkbox"/> Consumer-Driven Health Plan			<input type="checkbox"/> Limited Network Plan <input type="checkbox"/> Kelsey-Seybold <input type="checkbox"/> Village Family Practice <input type="checkbox"/> Renaissance			<input type="checkbox"/> Cigna Open Access			
Relationship	Last Name, First Name, M.I.		Gender	Medical (Add/Drop)	Dental (Add/Drop)	Vision (Add/Drop)	Date of Birth	Social Security No.	Tobacco User*
									<input type="checkbox"/>
									<input type="checkbox"/>
									<input type="checkbox"/>

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.

C. Medicare Information	
Please take out your red, white and blue Medicare card to complete this section. <ul style="list-style-type: none"> 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.
D. Medicare-Related Questions	
<input type="checkbox"/> Yes <input type="checkbox"/> No Do you or your spouse work?	
<input type="checkbox"/> Yes <input type="checkbox"/> No Do you have end-stage renal disease (ESRD)? If you've had a successful kidney transplant and/or you don't need regular dialysis any more, please attach a note or records from your doctor showing you've had a successful kidney transplant or you don't need dialysis. Otherwise, your chosen provider may need to contact you to obtain additional information. If yes, what is the date of your first dialysis treatment? Date: (month) _____ (year) _____	
<input type="checkbox"/> Yes <input type="checkbox"/> 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: _____ / _____ / _____	
<input type="checkbox"/> Yes <input type="checkbox"/> No Was your previous policy terminated? If yes, provide termination date: _____ / _____ / _____	
<input type="checkbox"/> Yes <input type="checkbox"/> No Are you a resident in a long-term care facility, such as a nursing home? If Yes, provide the following information: Name of institution: _____ Phone Number: (_____) _____ Address: _____ City: _____ State: _____ Zip Code: _____	
<input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Yes <input type="checkbox"/> 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 #: _____	
Please check one of the boxes below if you would prefer us to send you information in a language other than English or in an accessible format: <input type="checkbox"/> Spanish <input type="checkbox"/> Braille/Large Print	

E. Disclosures – Please initial beside your selected plan disclosure

Aetna Steerage PPO

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 the Aetna Medicare Advantage plan will automatically end my enrollment in another Medicare health plan. It is my responsibility to inform Aetna 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 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 that 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 confirms that: 1) this person is authorized under State law to complete this enrollment and 2) documentation on this authority is available upon request from Medicare.

(Initials) _____

Medicare Supplement Plan F

My signature indicates I have read and understand the contents of this enrollment form.

I declare that the answers on this enrollment form are complete and true to the best of my knowledge and belief and are the basis for issuing coverage. I understand that this enrollment form becomes part of the insurance contract and that if the answers are incomplete, incorrect or untrue, UnitedHealthcare Insurance Company may have the right to rescind my coverage, adjust my premium, or reduce my benefits.

Any person who, knowingly and with intent to defraud any insurance company or other person, files an enrollment form for insurance or statement of claim containing any materially false information, or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act when determined by a court of competent jurisdiction, and as such may be subject to criminal and civil penalties.

I understand the coverage under the plan I am enrolling in will not take effect until issued by United Healthcare Insurance Company.

(Initials) _____

KelseyCare Advantage HMO

KelseyCare Advantage is a Medicare Advantage plan and has a contract with the Federal government. I will need to keep my Medicare Parts A and B. I can be in only 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 or prescription drug plan. It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future. 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 when an enrollment period is available, or under certain special circumstances.

KelseyCare Advantage serves a specific service area, you must reside in one of the following counties in Texas: Harris, Fort Bend, Montgomery, Galveston, Liberty, Chambers, Waller, and Brazoria. If I move out of the area that KelseyCare Advantage serves, I need to notify the City of Houston so I can be disenrolled and find a new plan in my new area. Once I am a member of KelseyCare Advantage, I have the right to appeal plan decisions about payment or services if I disagree. I will read Evidence of Coverage document from KelseyCare Advantage 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 understand that beginning on the date KelseyCare Advantage coverage begins, I must get all of my health care from a KelseyCare Advantage network provider, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by KelseyCare Advantage and other services contained in my KelseyCare Advantage Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR KELSEYCARE ADVANTAGE WILL PAY FOR THE SERVICES.**

I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with KelseyCare Advantage, he/she may be paid based on my enrollment in KelseyCare Advantage.

Release of information: By joining this Medicare health plan, I acknowledge that KelseyCare Advantage will release my information to Medicare and other plan as is necessary for treatment, payment and health care operations. I also acknowledge that KelseyCare Advantage 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 that if I intentionally provide false information on this form, I will be disenrolled from the plan.

I understand that 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 that 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) _____

WellCare TexanPlus HMO

WellCare Health Plans, Inc. is an HMO, PPO, PFFS plan with a Medicare contract. Enrollment in our plans depends on contract renewal. I will need to keep my Medicare Parts A and B. I can be in only 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 or prescription drug plan. It is my responsibility to inform you of any prescription drug coverage that I have or may get 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 when an enrollment period is available (Example: Annual Open Enrollment Period from October 15 – December 7), or under certain special circumstances.

WellCare TexanPlus HMO serves a specific service area. If I move out of the area that WellCare TexanPlus HMO serves, I need to notify the plan so I can disenroll and find a new plan in my new area. Once I am a member of WellCare TexanPlus HMO, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage from WellCare TexanPlus HMO 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 are not usually covered under Medicare while out of the country, except for limited coverage near the U.S.

border.

I understand that beginning on the date WellCare TexanPlus HMO coverage begins, I must get all of my healthcare from WellCare TexanPlus HMO, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by WellCare TexanPlus HMO and other services contained in my WellCare TexanPlus HMO Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR WELLCARE TEXANPLUS HMO WILL PAY FOR THE SERVICES.** I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted by WellCare TexanPlus HMO, he or she may be paid based on my enrollment in WellCare TexanPlus HMO.

Release of Information: By joining this Medicare health plan, I acknowledge that WellCare TexanPlus HMO will release my information to Medicare, other plans and providers as is necessary for treatment, payment and healthcare operations. I also acknowledge that WellCare TexanPlus HMO will release my information, including my prescription drug event data if applicable, 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 that 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 that 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) _____

F. City of Houston Authorizations

I am a retiree or survivor of the City of Houston, eligible to participate in the Medical, Dental, and Vision programs. 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 of make a plan or tier change at the end of the month, you 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 Medical, Dental or Vision Provider to disclose to the Plan Administrator(s) information relating to individuals specified on this application.

Date	Contact Number	Signature