City of Houston Benefits Non-Medicare Retiree Open 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 bit.ly/COHBenefitsForm

Print or type with blue or black ink only

Employee ID	Pension System	RIO Participant	Gender
	☐ Municipal ☐ Fire ☐ Police	☐ Yes ☐ No	☐ Male ☐ Female

Phone Number	Email Address

First Name	Last Name	M.I.

Mailing Address or PO Box	Apt. No.	City	State	Zip	County

Permanent Address	Apt. No.	City	State	Zip	County

A. Group Benefits Choice: Complete for all applicable.

Opt out: I understand that I may re-enroll in the future Open Enrollment, or if I have a Qualifying Life Event
☐ Medical ☐ Dental ☐ Vision

Medical Plans (select one):
☐ Cigna Limited Network Plan
- ☐ Kelsey-Seybold
- ☐ Village Family Practice
- ☐ Renaissance

Physician 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
☐ DPPO

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

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

Are you or your eligible dependents Medicare-eligible? ☐ Yes ☐ No

If Yes, you are required to enroll in Medicare A & B.

Note: The City's 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. The City of Houston requires the enrollment of Medicare A & B if they are Medicare-eligible.

Signed acknowledgment: ____

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

Relationship	Last Name, First Name, M.I.	Gender	Medical	Dental	Vision	Date of Birth	Social Security No.	Tobacco User
Self/Retiree		☐ M ☐ F	☐ Add ☐ Drop	☐ Add ☐ Drop	☐ Add ☐ Drop			☐
		☐ M ☐ F	☐ Add ☐ Drop	☐ Add ☐ Drop	☐ Add ☐ Drop			☐
		☐ M ☐ F	☐ Add ☐ Drop	☐ Add ☐ Drop	☐ Add ☐ Drop			☐
		☐ M ☐ F	☐ Add ☐ Drop	☐ Add ☐ Drop	☐ Add ☐ Drop			☐
		☐ M ☐ F	☐ Add ☐ Drop	☐ Add ☐ Drop	☐ Add ☐ Drop			☐

C. Notes

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. 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. 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. ***You must complete a non-tobacco user form.***

Important: If both you and your spouse work(ed) for 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.

D. City of Houston Authorizations

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.

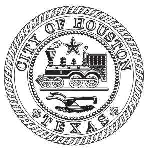
I authorize any Medicare Advantage Plan Provider to disclose to the Plan Administrator(s) information relating to individuals specified on this application.

Date	Phone Number	Signature

For Benefits Office use only

Department	Retirement Date	Effective Date

Revised September 22, 2021 2:44 PM



City of Houston Benefits Retiree/Survivor Dental/Vision Enrollment Form

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Print or type with blue or black ink only

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

Phone Number	Email Address

First Name	Last Name	M.I.

Mailing Address or PO Box	Apt. No.	City	State	Zip	County

Permanent Address	Apt. No.	City	State	Zip	County

Complete the following section for each person to be covered under a City Dental and/ or Vision Plan. Select a plan for yourself and each eligible dependent. You must currently be enrolled or opted out in order to be able to select, change plans or add dependents.

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

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

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

Opt out: I understand that I may re-enroll in the future Open Enrollment, or if I have a Qualifying Life Event
☐ Medical ☐ Dental ☐ Vision

Relationship	Last Name, First Name, M.I.	Gender	Dental	Vision	Date of Birth	Social Security No.
Self/Retiree		☐ M ☐ F	☐ Add ☐ Drop	☐ Add ☐ Drop		
		☐ M ☐ F	☐ Add ☐ Drop	☐ Add ☐ Drop		
		☐ M ☐ F	☐ Add ☐ Drop	☐ Add ☐ Drop		
		☐ M ☐ F	☐ Add ☐ Drop	☐ Add ☐ Drop		

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.

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