WASHOE COUNTY HUMAN RESOURCES

RETIREE HEALTH INSURANCE ENROLLMENT CHANGE FORM

Indicate your choice of Health Benefit Plan
Please Print

PPO Plan Hometown Health Network	☐	**PPO Plan UHNPPO Network**	☐	**High Deductible Health Plan UHNPPO Network**	☐	**High Deductible Health Plan Hometown Health Network**	☐	**Premier HMO Hometown Health**	☐	**Medicare Advantage Plan**	☐

HUMAN RESOURCES USE ONLY				
HIRE DATE	SAP #	TERM DATE	EFFECTIVE DATE	LOCATION

SOCIAL SECURITY NUMBER	RETIREE'S FIRST NAME	MI	LAST NAME	SEX
				MALE ☐ FEMALE ☐

RESIDENCE ADDRESS (NUMBER, STREET or RFD, CITY, STATE and ZIP CODE)	HOME PHONE	
		RETIREE ONLY ☐ RETIREE & CHILD (REN) ☐ RETIREE & SPOUSE OR DOMESTIC PARTNER ☐ RETIREE & FAMILY ☐

MARITAL STATUS (CHECK ONE) MARRIED ☐ DIVORCED ☐ SINGLE ☐ WIDOWED ☐	BIRTHDATE	DEPARTMENT RETIRED FROM

EMAIL ADDRESS _____

DATE OF RETIREMENT WITH PERS: _____ LAST DAY WORKED: _____

HAVE YOU ELECTED MEDICARE?
PART A ☐ EFFECTIVE DATE: _____
PART B ☐ EFFECTIVE DATE: _____
NEITHER OR NOT APPLICABLE ☐
MUST ATTACH A COPY OF MEDICARE CARD OR NOT APPLICABLE.

HAS YOUR SPOUSE ELECTED MEDICARE?
PART A ☐ EFFECTIVE DATE: _____
PART B ☐ EFFECTIVE DATE: _____
NEITHER OR NOT APPLICABLE ☐
MUST ATTACH A COPY OF MEDICARE CARD OR NOT APPLICABLE.

OPTIONAL DENTAL COVERAGE:

DO YOU WISH TO ELECT DENTAL COVERAGE? YES ☐ NO ☐

Dental benefits must be purchased for the retiree & all dependants.

LIST FAMILY MEMBERS TO BE ENROLLED ONLY	SEX M/F	BIRTHDATE	SOCIAL SECURITY NUMBER (REQUIRED)	IF HMO INDICATE ESTABLISHED PATIENT?
SPOUSE				YES ☐ NO ☐
DEPENDENT				YES ☐ NO ☐
DEPENDENT				YES ☐ NO ☐

BENEFICIARY INFORMATION FOR COUNTY PROVIDED LIFE INSURANCE

NAME AND ADDRESS OF BENEFICIARY (Birthday and Social Security Number required for spouse or child) — RELATIONSHIP

(Primary) _____ _____

_____ _____

(Contingent): _____ _____

_____ _____

PLEASE IDENTIFY ENROLLED MEMBERS WHO HAVE OTHER GROUP INSURANCE, MEDICARE OR MEDICAID AND THE EMPLOYER WHO PROVIDES IT.

NAME	EMPLOYER	INSURANCE CARRIER

I REQUEST THE INSURANCE PROVIDED BY THE COUNTY'S GROUP PLAN AND AUTHORIZE THE REQUIRED DEDUCTION (IF ANY) FROM MY WAGES ON A PRE-TAX BASIS AS ALLOWED UNDER SECTION 125 OF THE INTERNAL REVENUE CODE (IRC). I UNDERSTAND THAT, SHOULD I NOT ELECT DEPENDENT COVERAGE FOR MY DEPENDENTS AT THIS TIME, I MAY NOT AGAIN REQUEST FOR MY DEPENDENTS UNTIL THE ANNUAL ENROLLMENT OR AS ALLOWED BY SECTION 125 OF THE IRC.

BY SIGNING THIS FORM I AGREE FOR MYSELF AND ON BEHALF OF MY COVERED DEPENDENTS TO ABIDE BY THE RULES AND REGULATIONS OF MY CHOSEN HEALTH PLAN AND AUTHORIZE ANY HOSPITAL, PHYSICIAN OR OTHER LICENSED HEALTH CARE PROVIDER TO DISCLOSE ANY/OR ALL INFORMATION WITH RESPECT TO ANY ILLNESS, INJURY OR MEDICAL HISTORY REGARDING ME OR ANY OF MY DEPENDENTS TO THE CLAIMS ADMINISTRATOR/HMO OR UTILIZATION REVIEW/CASE MANAGEMENT COMPANY, OR THEIR AGENTS, UPON THEIR REQUEST. A PHOTOSTATIC COPY OF THIS AUTHORIZATION SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL.

X _____ _____
Signature Date

RETURN THIS FORM TO HUMAN RESOURCES

THE HEALTH BENEFITS PROGRAM DEFINES ELIGIBLE DEPENDENTS AS:

1) Your legal spouse or domestic partner.
2) Your child or children, as defined by your plan, up to and through the age of 26

Documentation may be required in some instances.

CHANGE IN FAMILY STATUS

THE GROUP HEALTH PLAN IS CONSIDERED PART OF SECTION 125 OF THE INTERNAL REVENUE CODE (IRC). ONCE ELECTION FOR COVERAGE IS MADE, THE IRS REGULATIONS WILL NOT PERMIT A CHANGE IN THIS COVERAGE UNTIL THE NEXT ANNUAL ENROLLMENT DATE, UNLESS THE CHANGE IS CONSISTENT WITH THE CHANGE IN FAMILY STATUS RULE, AS FOLLOWS:

MARRIAGE
DIVORCE, SEPARATION, RECONCILIATION (ONE TIME EACH YEAR)
BIRTH OR ADOPTION OF A CHILD
DEATH OF A DEPENDENT
YOUR SPOUSE STARTING OR LEAVING A JOB
CARRIER NO LONGER COVERS DEPENDENT