



HUMANA PREMIER HMO

RETIREES

Enrollment/Change Form

GROUP # 222869	BEN SEQ #	CLASS	PLAN #	OPTION #	EFFECTIVE DATE
-----Human Resources Use Only-----					

Job Title (while employed at MATC)		Social Security #		Email Address	
Last Name		First		M.I.	
Address		City		State	Zip
Date of Birth	Sex (M/F)	Marital Status	Home Phone #	Cell Phone #	
Type of Coverage <input type="checkbox"/> Retiree/Surviving Spouse only <input type="checkbox"/> Family (Retiree plus dependent(s))			Physician (Required)		
Status <input type="checkbox"/> Retiree <input type="checkbox"/> Surviving Spouse		Union (while employed at MATC) <input type="checkbox"/> Non-Represented <input type="checkbox"/> Local 212 Teacher <input type="checkbox"/> Local 212 Para-Professional <input type="checkbox"/> Local 587 <input type="checkbox"/> Local 715			

ELIGIBLE DEPENDENTS					Yes/No	
Last Name (If diff. from employee), First Name, MI	Sex (M/F)	Social Security #	Birth Date	Physician (Required)	Do you provide >50% support?	Is depend disabled ?
Spouse					N/A	N/A
Domestic Partner*					N/A	N/A
Child						
Child						
Child						

*Same sex partner only. Must attach supporting documentation (see HR for appropriate forms). **Only** applicable to retirees in the L212 union who retired after July 1, 2006.

Do you or any family member currently have other health coverage? Yes, single Yes, family No
 (Answer this question based on effective date of enrollment or change.)
 If yes to the above question, complete the following:
 Person's name _____
 Employer Name _____ Carrier Name _____ Plan Number _____

Are you or any of your dependents eligible for Medicare benefits? No Yes
 If yes, name _____, and Medicare Member # _____.

SEE REVERSE

Human Resources Use Only	
COSMO _____	Billing _____
Humana _____	SPD _____

ADDITIONAL DEPENDENTS

Last Name (If diff. from employee), First Name, MI	Sex (M/F)	Soc. Sec #	Birth Date	Physician (Required)	Do you provide >50% support?	Is depend. disabled?
Child						
Child						
Child						

COMPLETE THIS SECTION IF REQUESTING A CHANGE

Effective date of change: _____ **Please specify change and update in appropriate section.**

Retiree name change Retiree address change
 Birth Adoption Other coverage change Date of marriage _____
 Other _____ Date of divorce _____
 Add dependents Remove dependents Reason: _____

Spouse	SS#	Birth Date	Sex
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Domestic Partner*	SS#	Birth Date	Sex
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Dependent	SS#	Birth Date	Sex
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Dependent	SS#	Birth Date	Sex
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*Same sex partner only. Must attach supporting documentation (see HR for appropriate forms). **Only** applicable to retirees in the L212 union who retired after July 1, 2006.

I hereby apply for coverage and certify that all of the above information is true and correct. I understand that coverage will not be effective until all questions regarding eligibility for coverage have been satisfactorily resolved. I understand that I may not change the coverage elections that I make on the Retiree Enrollment/Change Form until the plan's next open/annual enrollment period or unless otherwise permitted by the Plan. Please refer to your Summary Plan Description for specific details of your benefit plan.

 RETIREE SIGNATURE
 (or SURVIVING SPOUSE)

 DATE

MATC is an Affirmative Action/Equal Opportunity Institution and complies with all requirements of the Americans with Disabilities Act.