Preferred Provider Option (PPO

RETIREE
Enrollment / Change Form

Benefits Administered by

☐ Open Enrollment ☐ Change (*complete change section on reverse side*)

GROUP NUMBER	CLASS #	RETIREE JOB LOCATION	EFFECTIVE DATE
----------HR USE ONLY----------			

JOB TITLE WHEN EMPLOYED	SOCIAL SECURITY #	EMAIL ADDRESS

LAST NAME	FIRST NAME	M.I.

ADDRESS	CITY	STATE	ZIP

DATE OF BIRTH	SEX (M/F)	MARITAL STATUS	HOME PHONE #	CELL PHONE #

Status	**Union (when employed at MATC)**
☐ Retiree ☐ Surviving Spouse	☐ Non-represented ☐ Local 212 Teacher ☐ Local 212 Para ☐ Local 587 ☐ Local 715

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______________

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 # ____________________.

If yes, name ____________________, and Medicare Member # ____________________.

Type of Coverage:

☐ Retiree only

☐ Family
(Retiree plus dependent(s))

HR USE ONLY			
COSMO	______________	Billing	______________
Fiserv	______________	SPD	______________

IF YOU ARE ELECTING OR CHANGING ANY OF THE ABOVE COVERAGES, PLEASE COMPLETE THE REMAINING SECTIONS OF THIS FORM ON THE REVERSE SIDE.

SEE REVERSE

COMPLETE THIS SECTION IF YOU ARE ELECTING *FAMILY COVERAGE* WHEN ENROLLING IN THE PLAN.

Last / Spouse Name First MI	SS#	BIRTH DATE	SEX			
______________________	____-____-____	____/____/____	____			
Domestic Partner*						
______________________	____-____-____	____/____/____	____			
Dependent Name(s)	SS#	BIRTH DATE	SEX	Relation to Employee	Do you provide more than 50% support?	Is dependent disabled?
1______________________	____-____-____	____/____/____	____	____	____	____
2______________________	____-____-____	____/____/____	____	____	____	____
3______________________	____-____-____	____/____/____	____	____	____	____
4______________________	____-____-____	____/____/____	____	____	____	____
5______________________	____-____-____	____/____/____	____	____	____	____

*Same sex partner only. Must attach supporting documentation. Applicable only to retirees in L212 union who retired after 7/1/06. Not applicable to L587 retirees.

COMPLETE THIS SECTION IF MAKING CHANGES
(After your initial enrollment in this Plan.)

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

☐ Retiree name change ☐ Retiree address change ☐ Location change

☐ Birth ☐ Adoption ☐ Other coverage change ☐ Date of marriage____________

☐ Other ______________________________________ ☐ Date of divorce____________

☐ Add dependents ☐ Remove dependents Reason: ______________________________

Spouse	SS#	Birth Date	Sex
Domestic Partner*	SS#	Birth Date	Sex
Dependent	SS#	Birth Date	Sex
Dependent	SS#	Birth Date	Sex

*Same sex partner only. Must attach supporting documentation. Applicable only to retirees in L212 union who retired after 7/1/06.Not applicable to L587 retirees.

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.