

**Retiree Health Plan  
Enrollment Form  
2010-2011**

Office Use Only
Pers.No
Eff. Date

**INSURED INFORMATION Please Print or type**

<b>Last Name</b>	<b>First Name</b>	<b>MI</b>	<b>Person ID or Soc. Sec. #</b>	<b>Sex</b>	<b>Marital Status</b>	
					<input type="checkbox"/> <b>Single</b> <input type="checkbox"/> <b>Married</b>	
<b>Home Address</b>	<b>City</b>	<b>State</b>	<b>Zip Code</b>	<b>Home Phone</b>	<b>Work Phone</b>	<b>Date of Birth</b>

<b>REASON FOR APPLICATION (CHECK ONE)</b>	<b>HEALTH PLAN</b>	<b>LEVEL OF COVERAGE</b>
<input type="checkbox"/> <b>New Enrollment</b> <input type="checkbox"/> <b>Open Enrollment</b> <input type="checkbox"/> <b>Name/Address Change</b> <input type="checkbox"/> <b>Change of Enrollment (Select reason of change)**</b> <input type="checkbox"/> <b>Marriage</b> <input type="checkbox"/> <b>Divorce</b> <input type="checkbox"/> <b>Family judgment, decree or court order</b> <input type="checkbox"/> <b>Birth/Adoption</b> <input type="checkbox"/> <b>Death</b> <input type="checkbox"/> <b>Dependent no longer eligible for coverage</b> <input type="checkbox"/> <b>Change in employment status of spouse or employee:</b> <b>Separation date from UK (if applicable):</b> _____ **Supporting documentation may be required	<b>UK Medicare Carveout Plans:</b> <input type="checkbox"/> <b>UK Carveout (Medical + Rx)</b> <input type="checkbox"/> <b>UK Carveout (Medical Only)</b> <input type="checkbox"/> <b>UK Carveout (Rx Only)</b> <input type="checkbox"/> <b>No Health Coverage</b>	<input type="checkbox"/> <b>Retiree Only</b> <input type="checkbox"/> <b>Retiree + Spouse</b> <input type="checkbox"/> <b>Retiree Spouse Only</b> <input type="checkbox"/> <b>Surviving Spouse</b>

**ADDITIONAL INFORMATION Select Add/Cancel for each individual you want to cover on your Health Plan**

Name (Last, First)	Date of Birth	Social Security #	Sex	Disabled Y/N	Relationship	Add	Cancel
<b>SPOUSE</b>							

<b>DEPENDENTS</b>							

**Are you or anyone listed above covered by another Group Health Plan? If so, you must complete the following:**

Name (Last, First)	Name and Address of Insurance Company	Coverage Level	Effective Date	Policy #

**Acknowledgement and Signature**

I understand that I have made the above plan election for the plan year. I confirm that the dependent information I have provided is correct to the best of my knowledge. I understand that the choices I have made on this form cannot be changed until the next enrollment period unless I have a change in family status as defined by law. If I do not complete and return a new Health Plan form during future enrollment periods, I will be treated as having elected to continue the elements of health coverage then in effect if the plan is still available (whether insured or self-insured) for the new plan year. In addition, these elections will apply to any changes to the amount of the required employee contribution for the health plans I have elected. Any person who knowingly and with intent to defraud any insurance company or other person files an application 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, which is a crime.

<b>Signature</b>	<b>Date</b>