

Effective date: \_\_\_\_\_

Office of Human Resources 1419 Salt Springs Road Phone: 315.445.4155

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## Pre-65 Retiree Open Enrollment Form Name: SSN: City, State Zip: Date of Birth: \_\_\_\_\_ Gender: \_\_\_\_ Email Address: \_\_\_\_\_\_ Phone #: \_\_\_\_\_ Medicare # (if applicable): \_\_\_\_\_\_ Part A Effective: \_\_\_\_\_ Part B Effective: \_\_\_\_\_ Please provide spouse information, only if he/she is currently covered as a dependent on your pre-65 insurance SSN Date of Birth Gender Relationship Please check coverage type and person(s) to be covered: Cancel coverage effective: Medical: Change in plan or persons covered PPO-J HealthyBlue single sub & spouse sub & spouse Please specify dependent to be removed (if applicable): \*Please note: you are not able to add your spouse to your coverage, only remove. Dental: Cancel coverage effective 12/31/2012 \*Please note: Once dental insurance is waived you will not be eligible to enroll at a later date. Participant Signature: \_\_\_\_\_\_\_Date: \_\_\_\_\_\_ To be completed by the employer: Benefit Log: \_\_\_\_\_ Delta Dental: \_\_\_\_

BCBS: \_\_\_\_\_