CITY SCHOOL DISTRICT
Telephone No.: 262-8206

HUMAN RESOURCES DEPARTMENT
EMPLOYEE BENEFITS

131 West Broad Street
Rochester, New York 14614

Every child is a work of art.
Create a masterpiece.

RETIREES' HEALTH INSURANCE TRANSFER/ELECTION FORM

Date _____

NAME _____ **BIRTH DATE** _____

ADDRESS _____ **Social Security No.** _____

_____ **Telephone No.** _____

(City/Town) (State) (Zip Code) **Email** _____

Please Check: ☐ Miss ☐ Ms. ☐ Widowed ☐ Married ☐ Separated
☐ Mrs. ☐ Mr. ☐ Single ☐ Divorced No. of unmarried children under 26 _____\

SPOUSE'S NAME _____ **SPOUSE'S BIRTH DATE** _____

Social Security No. _____

To ensure your future coverage, please fill in below the relative or other person - **LIVING AT ANOTHER ADDRESS** - whom we can contact should we be unable to reach you:

NAME _____ **RELATIONSHIP** _____

ADDRESS _____ **Telephone No.** ( ) _____
(No. & Street) (City/Town) (State) (Zip Code)

☒ I am a RETIREE of the City School District -- The DISTRICT PAYS BC/BS PREMIUM COST for persons employed full-time for 10 consecutive years immediately prior to retirement. (Less than 10 years, or not full-time, retiree NOT ELIGIBLE)
☐ I am a SURVIVOR of a RETIREE (or Employee) -- I PAY the full premium cost.

I want to enroll in:	**Plan Type** ☐ Enhanced (under 65) ☐ Medicare Blue Choice (+ 65) ☐ Retiree+ Enhanced EPO (+ 65) ☐ Preferred Gold Standard ☐ Preferred Gold Buy Up ☐ BlueCross/BlueShield (+ 65) ☐ Cancel All Coverage ☐ Waive (eligible to enroll at future open enrollments) ☐ No Change

My Spouse wants to enroll in:	**Plan Type** ☐ Enhanced (under 65) ☐ Medicare Blue Choice (+ 65) ☐ Retiree+ Enhanced EPO (+ 65) ☐ Preferred Gold Standard ☐ Preferred Gold Buy Up ☐ BlueCross/BlueShield (+ 65) ☐ Cancel All Coverage ☐ Waive (eligible to enroll at future open enrollments) ☐ No Change

Are you or any of your dependents eligible for Medicare (through Social Security)? If yes, please enclose a copy of your Medicare card.

☐ If you are a disabled retiree, or disabled spouse of a retiree, who became Medicare-eligible before age 65, you must contact Employee Benefits at 262-8206 for further information regarding enrollment regulations.

You will be billed for the premium cost above District contributions on a monthly basis. If the monthly bill is not paid, the retiree will be cancelled for non-payment. Retirees may re-enroll during the next annual open enrollment period.

The District's annual open enrollment period for retirees will occur each November for a January 1 effective date. **PLEASE COMPLETE and RETURN TO EMPLOYEE BENEFITS**

RETIREMENT TRANSFER/CHANGE DATE _____

_____ _____
(Signature) (Date)

OFFICE USE ONLY

BENEFIT PROGRAM _____

EMPLOYEE I.D. _____