BI·STATE DEVELOPMENT

☐ **New address and/or phone #**

**If checked, BSD system will be updated**

# RETIREE MEDICAL ENROLLMENT FORM (PLEASE PRINT)

**A** QUALIFYING EVENT

☐ DIVORCE/LEGAL SEPARATION ☐ OPEN ENROLLMENT ☐ RETIREMENT
☐ DEATH OF SPOUSE/INCAPACITATED CHILD ☐ OTHER _____

EFFECTIVE DATE OF CHANGE (MM/DD/CCYY)

**B**

| RETIREE LAST NAME | RETIREE FIRST NAME | MI | RETIREE SOCIAL SECURITY NO. |
|---|---|---|---|
| | | | __ __ __ - __ __ - __ __ __ __ |

| RETIREE DATE OF BIRTH (MM/DD/CCYY) | HOME PHONE | CELL PHONE | RETIREE BADGE NO. |
|---|---|---|---|
| | ( ) | ( ) | |

| STREET ADDRESS | CITY | STATE | ZIP CODE |
|---|---|---|---|
| | | | |

**C** DEPENDENTS: **NOTE: ***NO CHANGES WILL BE MADE TO DEPENDENTS NOT LISTED BELOW***. DEPENDENTS NOT CURRENTLY COVERED MAY NOT BE ADDED.**

| RELATION | MEDICAL/RX | LAST NAME | FIRST NAME | MI | SOCIAL SECURITY NO. ###-##-#### | DATE OF BIRTH MM/DD/CCYY | GENDER |
|---|---|---|---|---|---|---|---|
| SPOUSE | ☐ ADD ☐ REMOVE | | | | __ __ __ - __ __ - __ __ __ __ | __ __ / __ __ / __ __ __ __ | ☐ M ☐ F |
| INCAPACITATED CHILD | ☐ ADD ☐ REMOVE | | | | __ __ __ - __ __ - __ __ __ __ | __ __ / __ __ / __ __ __ __ | ☐ M ☐ F |

**D**

MEDICAL PLAN: ☐ Premium ☐ Preferred ☐ Economy ☐ Opt Out of Coverage

**E**

**SIGNATURE** – The information provided above is true and correct to the best of my knowledge, and I accept the provisions on the reverse side of this form which I have read and understand.

| RETIREE'S SIGNATURE | PRINT RETIREE NAME | DATE |
|---|---|---|
| | | |

9/17

***Please read the reverse side carefully***

***Please read the following carefully.***

1. I hereby request coverage as specified and authorize deductions from my pension for my portion of the cost of the benefits.
2. Retirees may only remove dependents (spouse or incapacitated dependent child) from coverage or change the coverage option (Premium, Preferred or Economy) after the retirement date.
3. I understand that misrepresentation in completing this form, or non-payment of my share of the premium, may result in cancellation of coverage.
4. I understand that it is my responsibility to report to the Plan any change in the eligibility of my dependents.
5. Per IRS guidelines, this enrollment form and supporting documentation must be received by HR-Benefits within 31 days of your retirement date or the date of the qualifying event for changes to be made outside of the yearly open enrollment.
6. Return completed form to: Bi-State Development/HR-Benefits, Mailstop 125, 211 North Broadway, Suite 700, St. Louis, MO 63102