Group Retiree Health Insurance Plan & Medicare Part D Rx Plan Enrollment Form

Policy Number: 2947 – United American Insurance

Employer: City of San Angelo

Effective Date:

Please print clearly in ink or type

Retiree's Name: _____
First Middle Last

Street: _____

City, State, Zip: _____ Medicare/ HIC # _____

Phone Number: _____ Email Address: _____

Gender ☐ Male ☐ Female Date of Birth _____ Social Security # _____

Date of Retirement _____ Have you enrolled in Medicare Part B? ☐ Yes ☐ No

If no, when do you intend to enroll? _____

Dependent Spouse's Name :_____
First Middle Last

Gender ☐ Male ☐ Female Date of Birth _____ Social Security # _____

Medicare/ HIC # _____ Date of Retirement _____

Has your dependent spouse enrolled in Medicare Part B? ☐ Yes ☐ No

If no, when does he/ she intend to enroll? _____

To the best of your knowledge:

Do you or your dependent spouse have any other health insurance including an employer health plan?

Retiree ☐ Yes ☐ No **Spouse** ☐ Yes ☐ No

If so, with which company? What kind of policy? _____

Covered Person	Company Name	Policy Number	Kind of Policy	Effective Date	Expiration Date

2. If the answer to question 1 is yes, do you or your spouse intend to replace these medical or health policies with this policy or certificate?
   Retiree ☐ Yes ☐ No **Spouse** ☐ Yes ☐ No

   If yes, for what reason are you or your dependent spouse replacing the coverage?

   ☐ Additional Benefits
   ☐ Fewer benefits and lower premiums
   ☐ Integration with Medicare
   ☐ No change in benefits, but lower premiums
   ☐ Other (please specify)

3. Are you covered by Medicaid?

Retiree ☐ Yes ☐ No **Spouse** ☐ Yes ☐ No

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1) **PLEASE ENTER YOUR NAME EXACTLY AS IT APPEARS ON YOUR MEDICARE CARD;**

2) **ALSO PLEASE ENTER YOUR MEDICARE CLAIM NUMBER EXACTLY AS IT APPEARS ON YOUR MEDICARE CARD.**

MEDICARE HEALTH NSURANCE 1-800-MEDICARE (1-800-633-4227) **NAME OF BENEFICIARY**
MEDICARE CLAIM NUMBER GENDER _____ _____ IS ENTITLED TO EFFECTIVE DATE HOSPITAL (PART A) _ _ - _ _ - _ _ _ _ MEDICAL (PART B) _ _ - _ _ - _ _ _ _

Complete this form answering all questions. Please be sure to date and sign the form and return to:

City of San Angelo
Attn: Christine Russell
72 W. College Suite 201
San Angelo, TX 76903

Date: _____ Retiree Signature: _____

Date: _____ Spouse Signature: _____