2019 Plan Year
Pre-65 Retiree
Benefits Enrollment Form

For Internal Use Only:

☐ *Annual Enrollment*
☐ *Change in Status*
Reason: ______________________________
(Documentation required for qualifying events.)

Effective Date: ________________
(Required)
SAFD Pension Deduction ☐ Yes ☐ No
TMRS Public Safety Deduction ☐ Yes ☐ No

Retiree Information (please print above lines)

Retiree Name (Last)	(First)	(M.I.)	Gender M / F	Social Security Number - -	Marital Status
Mailing Address	Apt #	City	State	Zip Code	
Home/Cell Phone # ( )	Alternate Phone # ( )	Email Address	Date of Birth (mm/dd/yy) / /		

Please indicate your enrollment election by checking the appropriate box.

Retirees hired prior to 1/1/2000 AND retired prior to 1/1/2010 (regardless of number of years of service) OR
Retirees hired prior to 1/1/2000 and retired on or after 1/1/2010 with 20 or more years of service with COSA.
(City pays 100% of City contribution and retiree pays retiree rate only)

Health Plan	Aetna Low	Aetna Medium	Aetna High
Retiree Only (U65)	☐$20.44	☐$140.02	☐$223.48
Health Plan	Aetna Low	Aetna Medium	Aetna High
Retiree (U65) & Spouse (U65)	☐$418.36	☐$677.20	☐$843.30
Health Plan	Aetna Low	Aetna Medium	Aetna High
Retiree (U65) & Spouse (O65)	☐$325.44	☐$445.02	☐$528.48
Health Plan	Aetna Low	Aetna Medium	Aetna High
Retiree (U65) & Child(ren)	☐$277.74	☐$481.88	☐$617.92
Health Plan	Aetna Low	Aetna Medium	Aetna High
Retiree (U65) & Family	☐$578.26	☐$872.54	☐$1,068.70
☐ **I decline medical coverage and understand that I may be subject to plan limitations.**			

Please indicate your enrollment election by checking the appropriate box.

Retirees hired prior to 1/1/2000 and retired on or after 1/1/2010 with
15 years up to 19 years, 11 months of service with COSA.
(City pays 75% of City contribution and retiree pays 25% of City contribution in addition to the retiree rate)

Health Plan	Aetna Low	Aetna Medium	Aetna High
Retiree Only (U65)	☐$144.64	☐$264.22	☐$347.68
Health Plan	Aetna Low	Aetna Medium	Aetna High
Retiree (U65) & Spouse (U65)	☐$542.56	☐$801.40	☐$967.50
Health Plan	Aetna Low	Aetna Medium	Aetna High
Retiree (U65) & Spouse (O65)	☐$449.64	☐$569.22	☐$652.68
Health Plan	Aetna Low	Aetna Medium	Aetna High
Retiree (U65) & Child(ren)	☐$401.94	☐$606.08	☐$742.12
Health Plan	Aetna Low	Aetna Medium	Aetna High
Retiree (U65) & Family	☐$702.46	☐$996.74	☐$1,192.90
☐ **I decline medical coverage and understand that I may be subject to plan limitations.**			

Please indicate your enrollment by checking the appropriate box.

Retirees hired prior to 1/1/2000 and retired on or after 1/1/2010 with 5 years up to 14 years, 11 months of service with COSA OR Retirees hired on or after 1/1/2000 and retire from COSA. (Retiree pays 100% of total cost)

Health Plan	Aetna Low	Aetna Medium	Aetna High
Retiree Only (U65)	☐$517.22	☐$636.80	☐$720.26
Health Plan	Aetna Low	Aetna Medium	Aetna High
Retiree (U65) & Spouse (U65)	☐$915.14	☐$1,173.98	☐$1,340.08
Health Plan	Aetna Low	Aetna Medium	Aetna High
Retiree (U65) & Spouse (O65)	☐$822.22	☐$941.80	☐$1,025.26
Health Plan	Aetna Low	Aetna Medium	Aetna High
Retiree (U65) & Child(ren)	☐$774.52	☐$978.66	☐$1,114.70
Health Plan	Aetna Low	Aetna Medium	Aetna High
Retiree (U65) & Family	☐$1,075.04	☐$1,369.32	☐$1,565.48

☐ **I decline medical coverage and understand that I may be subject to plan limitations.**

Please indicate your enrollment election by checking the appropriate box.

Dental Plan	Retiree Only	Retiree + Spouse	Retiree + Children	Retiree + Family
Low Option	☐$18.40	☐$45.28	☐$57.14	☐$84.02
Dental Plan	Retiree Only	Retiree + Spouse	Retiree + Children	Retiree + Family
High Option	☐$20.05	☐$49.13	☐$61.96	☐$91.05

☐ **I decline dental coverage and understand that I may be subject to plan limitations.**

Please indicate your enrollment election by checking the appropriate box.

Vision Plan	Retiree Only	Retiree + Spouse	Retiree + Children	Retiree + Family
Low Option	☐$5.15	☐$9.05	☐$9.57	☐$14.40
Vision Plan	Retiree Only	Retiree + Spouse	Retiree + Children	Retiree + Family
High Option	☐$6.03	☐$10.30	☐$10.92	☐$16.33

☐ **I decline vision coverage and understand that I may be subject to plan limitations.**

Complete DEPENDENT information relating to your elections above

(please attach a separate sheet to list additional dependents)

(A)dd (C)hange (D)elete	Rel Code*	Coverage Elected	Last Name	First Name	MI	Social Security Number	Date of Birth mm/dd/yy	Gender
		☐ Med ☐ Den ☐ Vis						M / F
		☐ Med ☐ Den ☐ Vis						M / F

*Please enter the corresponding Relationship Code: Spouse = SPS Son = SON Daughter = DAU

Certifications, Acknowledgement and Signature

I have read this form and the other materials given to me about my benefits, and certify that the information I have supplied is true and correct. I understand that misstatements, misrepresentations or omissions may result in my coverage being canceled as of its effective date. In addition, I understand that intentionally providing false information constitutes fraud and is subject to disciplinary procedures, up to and including termination. I also understand that any person who knowingly provides false, incomplete or misleading facts or information to any insurer may be found guilty of insurance fraud, which is a crime, and may be subject to both civil and criminal penalties.

I understand that the benefit coverages I elect on this form will be in effect for the remainder of the 2019 Plan Year unless I experience a qualified status change or special enrollment event.

Any administrative error by the City, whether unintentional or inadvertent, does not relieve me of the responsibility to make the necessary and required contributions to the City-sponsored employee benefit programs. I will notify the City of San Angelo's Human Resources Department in writing immediately upon discovering any discrepancy in my voluntary contributions.

Retiree Signature: ______________________________ **Date:** ________________