2019 Post-65 Retiree or Split Rate 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 # ( )	Work 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				
Retiree Only (O65)	United American ☐$20.44			
Retiree (O65) & Spouse (O65)	United American ☐$325.44			
Retiree (O65) & Spouse (U65)		Aetna Low ☐$418.36	Aetna Medium ☐$557.62	Aetna High ☐$640.26
Retiree (O65) & Child(ren)		Aetna Low ☐$277.74	Aetna Medium ☐$362.30	Aetna High ☐$414.88
Retiree (O65) & Family		Aetna Low ☐$578.26	Aetna Medium ☐$752.96	Aetna High ☐$865.66

☐ 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				
Retiree Only (O65)	United American ☐$96.69			
Retiree (O65) & Spouse (O65)	United American ☐$401.69			
Retiree (O65) & Spouse (U65)		Aetna Low ☐$494.61	Aetna Medium ☐$633.87	Aetna High ☐$716.51
Retiree (O65) & Child(ren)		Aetna Low ☐$353.99	Aetna Medium ☐$438.55	Aetna High ☐$491.13
Retiree (O65) & Family		Aetna Low ☐$654.51	Aetna Medium ☐$829.21	Aetna High ☐$941.91

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

Health Plan				
Health Plan Retiree Only (O65)	United American ☐$325.44			
Health Plan Retiree (O65) & Spouse (O65)	United American ☐$630.44			
Health Plan Retiree (O65) & Spouse (U65)		Aetna Low ☐$723.36	Aetna Medium ☐$862.62	Aetna High ☐$945.26
Health Plan Retiree (O65) & Child(ren)		Aetna Low ☐$582.74	Aetna Medium ☐$667.30	Aetna High ☐$719.88
Health Plan Retiree (O65) & Family		Aetna Low ☐$883.26	Aetna Medium ☐$1,057.96	Aetna High ☐$1,170.66

☐ **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				
Dental Plan Low Option	Retiree Only ☐$18.40	Retiree + Spouse ☐$45.28	Retiree + Child(ren) ☐$57.14	Retiree + Family ☐$84.02
Dental Plan High Option	Retiree Only ☐$20.05	Retiree + Spouse ☐$49.13	Retiree + Child(ren) ☐$61.96	Retiree + Family ☐$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				
Vision Plan Low Option	Retiree Only ☐$5.15	Retiree + Spouse ☐$9.05	Retiree + Child(ren) ☐$9.57	Retiree + Family ☐$14.40
Vision Plan High Option	Retiree Only ☐$6.03	Retiree + Spouse ☐$10.30	Retiree + Child(ren) ☐$10.92	Retiree + Family ☐$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 (Change (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:** ____________________________