

CITY OF CHARLESTON

Retiree

BENEFIT PLAN ENROLLMENT CARD

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Medical Loc. Dental Loc. Sup. Code

-Retiree -Widow

Effective Date of Coverage

____/____/____

Hire Date

____/____/____

Department

Member Information

Name _____
(First) (Middle) (Last)

Social Security Number

Address _____
Street City State Zip Code

Date of Birth: ____/____/____

Marital Status: -Single -Married -Widowed -Divorced

Telephone Number: Phone # _____

Alternate Phone # _____

MEDICALDENTAL/VISIONDENTAL/VISION PLAN OPTION

Sex

Male

Female

elect single

elect member + one child

elect member + spouse

elect family

do no elect coverage

elect single

elect family

do no elect coverage

Standard

Enhanced

Names of Dependents To Be Covered:

Name	Social Security Number			Relationship	Sex M/F	Birthdate	Full Time Student Y/N	Handicapped Y/N

ABOUT YOUR OTHER GROUP OR NON-GROUP HEALTH INSURANCE COVERAGE AND MEDICARE

Do you or any of your dependents have other health coverage? Yes No If "YES", complete the following boxes

Name(s) of Covered Persons	Name of Other Insurance Co.	Policy Number	Effective Date/Cancel Date	Coverage Type(s)	
				O Medical	O Prescription Drug
				O Dental	O Vision

Medicare Information - Check the appropriate boxes and fill in all information for you and dependents who are covered by Medicare.

*Check box below for each individual receiving treatment for end-stage renal disease.

O-You	Medicare#	Eff. Date - Part A:	Part B:		Renal Disease
O-Spouse	Medicare#	Eff. Date - Part A:	Part B:		Renal Disease
O-Dependent	Medicare#	Eff. Date - Part A:	Part B:		Renal Disease

Do any of the dependents listed above live in a different city? Y or N -- If Yes list below the dependent(s) and the city and state in which they live.

1. Dependent _____ City & State 2. Dependent _____ City & State

Member Signature

Date

(Please check other side)

Healthcare Premium Discount Enrollment Verification

Overview & Instructions: The City of Charleston offers a Non-Tobacco User (NTU) healthcare premium discount. If you enroll in the City's healthcare plan, **you must select one (1) box in below.** Please complete the form in its entirety.

Healthcare Premium Selection (Please Select only 1 Box)

☐

Standard Rate: Select this option if you and/or applicable spouse are a Tobacco User.

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Non-Tobacco User (NTU) Discount: Select this option if you would like to receive a reduced discounted rate for being a non-tobacco user. To participate and be eligible to receive a reduced discounted healthcare premium, you must certify that you and your covered spouse, if applicable, do not use tobacco products.

Certification

By signing below, I do hereby certify, acknowledge and agree the information provided herein is true, accurate and complete to the best of my knowledge.

Member Signature

Date