



Retiree Benefits 2010

City of Anaheim

1. RETIREE INFORMATION

EMPLOYEE ID:

RETIRED:

MEDICAL:

TYPE

CITY CONTR:

DENTAL:

CITY CONTR:

* Medicare Assignment Plans - See calculation sheet for applicable plan costs, which may zero out premium.

FOR COVERAGE FROM JANUARY 1, 2010 THROUGH DECEMBER 31, 2010. PLEASE RETURN BY OCTOBER 21, 2009.

2. YOUR SELECTION -CHECK THE APPROPRIATE BOXES BELOW, PLEASE PRINT FIRMLY OR TYPE.

MEDICAL PLANS

Please check if NO CHANGE on Medical

	RETIREE		SPOUSE/DOMESTIC PARTNER		DEPENDENT	
	ENROLL	CANCEL	ENROLL	CANCEL	ENROLL	CANCEL
KAISER HMO	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
AETNA HMO	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
AETNA OAMC (PPO)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
AETNA HIGH OPTION OAMC (PPO)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
MEDICARE ASSIGNMENT (MUST HAVE A & B)						
AETNA MEDICARE HMO	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
KAISER SENIOR ADVANTAGE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PACIFICARE SECURE HORIZONS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
AETNA PRIVATE FEE FOR SERVICE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

DENTAL PLANS

Please check if NO CHANGE on Dental

	RETIREE		SPOUSE/DOMESTIC PARTNER		DEPENDENT	
	ENROLL	CANCEL	ENROLL	CANCEL	ENROLL	CANCEL
DELTA CARE USA DMO	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
DELTA DENTAL PPO	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

3. WHO YOU ARE COVERING (Please Print)

Last Name	First Name	Relationship	Date of Birth	Plans	SSN (Required)

Please read the attached form for additional information and SIGN on the authorization line on the next page.





4. MEDICARE - PLEASE COMPLETE, NO EXCEPTIONS

Complete this section if you and/or your eligible family members are enrolled or enrolling in Medicare. Please read the instructions below, ATTACH A COPY OF EACH FAMILY MEMBERS MEDICARE CARD TO THIS FORM, IF YOU HAVE NOT ALREADY DONE SO.

	Hospital Insurance Effective Date(Part A)	Medical Insurance Effective Date(Part B)	Medicare Claim Number Insurance
I am enrolled in Medicare:			
My Spouse/Domestic Partner is enrolled in Medicare:			
My Child is enrolled in Medicare:			

If you or a family member(s) are in the process of enrolling in Medicare, please check the appropriate box(es) below. It is your responsibility to supply the City with a copy of your Medicare card as soon as you receive it.

I am in the process of enrolling.

My spouse/domestic partner is in the process of enrolling.

My child is in the process of enrolling.

5. YOUR AUTHORIZATION

I agree to pay premiums when billed and understand that failure to pay when payment is due will result in cancellation of my insurance. I also authorize the plan or care provider to release any or all medical information for myself or covered family members when information is needed to process medical plan claims. I further recognize that I must notify Human Resources promptly when dependents are ineligible for benefits. Failure to notify the City of Anaheim may subject me to repayment of the premium costs to cover ineligible dependents.

I understand that the City of Anaheim reserves the right to modify retiree medical coverages. I understand that the benefits of the plan I choose are coordinated with those provided under any other group hospital, medical benefit or service plan. Any controversy between a plan member and the plan or care provider is subject to binding arbitration. This binding arbitration does not apply to Kaiser Senior Advantage members.

I elect to be covered under the option(s) I've checked on the reverse side, until I make another choice during a future open enrollment period. I understand the provisions of the choice I've selected.

Signature _____

Date _____

How to Complete Your Enrollment Form

Section 1: Check all the personal information shown for accuracy.

Section 2: Choose one of the plans offered by the City of Anaheim. Check the appropriate box(es) for you and your spouse/domestic partner and dependent(s), if applicable. Keep in mind that if you're eligible for Medicare, you might save money by enrolling in a plan specifically for people on Assignment Only plans. Next, select a dental plan if you are eligible. You are eligible for dental coverage if :
* You enrolled in a City dental plan for 2009, and
* You retired on or after 1/1/88, or
* You were a police bargaining unit employee and retired on or after 7/1/85.
* IBEW bargaining unit employees ARE NOT ELIGIBLE for dental benefits.

Section 3: Please complete a line for each family member you wish to cover. List your spouse/domestic partner, and other dependents. If you need more space, use a separate piece of paper and return it with your form. Remember, you must have eligible dependents to enroll in City benefits.

Section 4: Complete this section only if you, or an eligible family member, are currently enrolled or applying for Medicare.

Section 5: Read the authorization and sign and date the form.

Return this form to the City of Anaheim Benefits Office by October 21, 2009, along with a copy of any Medicare card(s), if applicable.

