



# Retiree Health Program Enrollment/Change Form

Please print or type. Check appropriate boxes.

## A. RETIREE OR SURVIVING SPOUSE INFORMATION

Management  Weekly

Name: Last \_\_\_\_\_ First \_\_\_\_\_ M.I. \_\_\_\_\_ Employee Number \_\_\_\_\_

Home Address: Street \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Telephone \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Soc. Sec. No. \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Date of Birth \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Sex \_\_\_\_\_  Single  Married  Domestic Partner  Legally Separated/Divorced Date of Marriage \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**MEDICARE:** If eligible, copy the following information from your Medicare Health Insurance Card:

Medicare Claim Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  Over 65  Disabled and under 65

## B. SPOUSE/DOMESTIC PARTNER INFORMATION - Surviving spouse should fill out Section A above.

Name of Spouse/Domestic Partner: Last \_\_\_\_\_ First \_\_\_\_\_ M.I. \_\_\_\_\_

Soc. Sec. No. \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Date of Birth \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**MEDICARE:** If your spouse/domestic partner is eligible, copy the following information from your spouse/domestic partner's Medicare Health Insurance Card:

Medicare Claim Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  Over 65  Disabled and under 65

## C. ENROLLMENT - Directions: For initial enrollment, complete section 1; to disenroll from an HMO, complete section 2; to disenroll from prescription drug coverage, complete section 3; to disenroll from medical coverage, complete section 4; to change enrollment, complete section 5; to enroll dependent(s), complete section 6.

I have read the Retiree Health Program summary plan description and descriptive material from the HMOs located in my service area. I elect to enroll, disenroll and/or change my enrollment for myself, my spouse/domestic partner and/or my dependent child(ren) as indicated below.

1. I will be eligible for coverage under the Retiree Health Program as of Month \_\_\_\_\_ Year \_\_\_\_\_ and I elect to enroll in  CIGNA  HMO Option\*  Caremark Prescription Drug  Retired Officers' Plan  CIGNA and Caremark or  not to enroll

I understand that I must enroll in the options above within 31 days of becoming eligible for coverage. I may not be able to enroll in the future unless I provide proof of continuous coverage with another group health plan, and that, if enrolled in CIGNA or the HMO Option, I may change my coverage during open enrollment. I understand that CIGNA and the HMO Option coordinate with Medicare and Medicare recipients must have both Original Medicare Part A and Part B coverage to ensure maximum benefits under the program. I also understand that if I enroll for prescription drug coverage *only* or medical coverage *only*, I will not be covered by any other Con Edison retiree health or prescription care benefits, and that once I enroll in this benefit, I cannot change my enrollment to any other Con Edison retiree health care plan except during open enrollment.

2. I elect to disenroll from HMO coverage as of Month \_\_\_\_\_ Year \_\_\_\_\_

List HMO name and service area: \_\_\_\_\_

Call Employee Benefits to request a disenrollment form.

3. I elect to disenroll from prescription drug coverage as of Month \_\_\_\_\_ Year \_\_\_\_\_

4. I elect to disenroll from medical coverage as of Month \_\_\_\_\_ Year \_\_\_\_\_

5. I elect to change my enrollment to  CIGNA  HMO Option\*  Caremark Prescription Drug  Retired Officers' Plan  CIGNA and Caremark as of Month \_\_\_\_\_ Year \_\_\_\_\_

\* Complete the following if you elect the HMO Option in sections 2 or 5 above:

List HMO name and service area: \_\_\_\_\_

List name of primary care physician for: \_\_\_\_\_ (Retiree) (Spouse/Domestic Partner) (Dependent Child(ren))

If you are Medicare-eligible, you must call Employee Benefits to receive a HCFA enrollment form.

6. Under the plan I elected above, I wish to enroll (not to enroll) my dependents as follows:

If you enroll in an HMO, your Medicare-eligible spouse/ domestic partner and dependent child(ren) must sign below.

	Retiree Health Plan	HMO	Prescription Drugs	Retired Officers' Plan	Elect not to enroll
My spouse/domestic partner	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My dependent child(ren)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Spouse/Domestic Partner's Signature (if Medicare-eligible) \_\_\_\_\_ Date \_\_\_\_\_

Child's Signature (if Medicare-eligible) \_\_\_\_\_ Date \_\_\_\_\_

## DEPENDENT CHILDREN INFORMATION: If you have more than two dependent children, please attach an additional sheet.

First Name	MI	Last Name	Sex		Date of Birth	Handicapped		Social Security Number	Full-Time Student		Name of school if full-time student over age 19
			M	F		Yes	No		Yes	No	

**MEDICARE:** If your handicapped child is eligible, copy the Medicare claim number from your child's Medicare Health Insurance Card: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

## D. AUTHORIZATION

I authorize Consolidated Edison Company of New York, Inc. to deduct from my retirement benefit each month the applicable contribution toward the cost of CIGNA, the HMO Option, Caremark prescription drug coverage, Caremark and CIGNA or the Retired Officers' Plan for the person(s) indicated above. My election shown above and this authorization shall continue in force unless I change it by completing an Enrollment/Change Form and filing it with Employee Benefits at the address listed above. I understand that Con Edison reserves the right to change or terminate retiree health benefits at any time.

Retiree Signature \_\_\_\_\_ Date \_\_\_\_\_



# Retiree Health Program Enrollment/Change Form

Please print or type. Check appropriate boxes.

## A. RETIREE OR SURVIVING SPOUSE INFORMATION

Management  Weekly

Name: Last \_\_\_\_\_ First \_\_\_\_\_ M.I. \_\_\_\_\_ Employee Number \_\_\_\_\_

Home Address: Street \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Telephone \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Soc. Sec. No. \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Date of Birth \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Sex \_\_\_\_\_  Single  Married  Domestic Partner  Legally Separated/Divorced Date of Marriage \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**MEDICARE:** If eligible, copy the following information from your Medicare Health Insurance Card:

Medicare Claim Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  Over 65  Disabled and under 65

## B. SPOUSE/DOMESTIC PARTNER INFORMATION - Surviving spouse should fill out Section A above.

Name of Spouse/Domestic Partner: Last \_\_\_\_\_ First \_\_\_\_\_ M.I. \_\_\_\_\_

Soc. Sec. No. \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Date of Birth \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**MEDICARE:** If your spouse/domestic partner is eligible, copy the following information from your spouse/domestic partner's Medicare Health Insurance Card:

Medicare Claim Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  Over 65  Disabled and under 65

## C. ENROLLMENT - Directions: For initial enrollment, complete section 1; to disenroll from an HMO, complete section 2; to disenroll from prescription drug coverage, complete section 3; to disenroll from medical coverage, complete section 4; to change enrollment, complete section 5; to enroll dependent(s), complete section 6.

I have read the Retiree Health Program summary plan description and descriptive material from the HMOs located in my service area. I elect to enroll, disenroll and/or change my enrollment for myself, my spouse/domestic partner and/or my dependent child(ren) as indicated below.

1. I will be eligible for coverage under the Retiree Health Program as of Month \_\_\_\_\_ Year \_\_\_\_\_ and I elect to enroll in  CIGNA  HMO Option\*  Caremark Prescription Drug  Retired Officers' Plan  CIGNA and Caremark or  not to enroll

I understand that I must enroll in the options above within 31 days of becoming eligible for coverage. I may not be able to enroll in the future unless I provide proof of continuous coverage with another group health plan, and that, if enrolled in CIGNA or the HMO Option, I may change my coverage during open enrollment. I understand that CIGNA and the HMO Option coordinate with Medicare and Medicare recipients must have both Original Medicare Part A and Part B coverage to ensure maximum benefits under the program. I also understand that if I enroll for prescription drug coverage *only* or medical coverage *only*, I will not be covered by any other Con Edison retiree health or prescription care benefits, and that once I enroll in this benefit, I cannot change my enrollment to any other Con Edison retiree health care plan except during open enrollment.

2. I elect to disenroll from HMO coverage as of Month \_\_\_\_\_ Year \_\_\_\_\_

List HMO name and service area: \_\_\_\_\_

Call Employee Benefits to request a disenrollment form.

3. I elect to disenroll from prescription drug coverage as of Month \_\_\_\_\_ Year \_\_\_\_\_

4. I elect to disenroll from medical coverage as of Month \_\_\_\_\_ Year \_\_\_\_\_

5. I elect to change my enrollment to  CIGNA  HMO Option\*  Caremark Prescription Drug  Retired Officers' Plan  CIGNA and Caremark as of Month \_\_\_\_\_ Year \_\_\_\_\_

\* Complete the following if you elect the HMO Option in sections 2 or 5 above:

List HMO name and service area: \_\_\_\_\_

List name of primary care physician for: \_\_\_\_\_ (Retiree) (Spouse/Domestic Partner) (Dependent Child(ren))

If you are Medicare-eligible, you must call Employee Benefits to receive a HCFA enrollment form.

6. Under the plan I elected above, I wish to enroll (not to enroll) my dependents as follows:

If you enroll in an HMO, your Medicare-eligible spouse/ domestic partner and dependent child(ren) must sign below.

	Retiree Health Plan	HMO	Prescription Drugs	Retired Officers' Plan	Elect not to enroll
My spouse/domestic partner	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My dependent child(ren)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Spouse/Domestic Partner's Signature (if Medicare-eligible) \_\_\_\_\_ Date \_\_\_\_\_

Child's Signature (if Medicare-eligible) \_\_\_\_\_ Date \_\_\_\_\_

## DEPENDENT CHILDREN INFORMATION: If you have more than two dependent children, please attach an additional sheet.

First Name	MI	Last Name	Sex		Date of Birth	Handicapped		Social Security Number	Full-Time Student		Name of school if full-time student over age 19
			M	F		Yes	No		Yes	No	

**MEDICARE:** If your handicapped child is eligible, copy the Medicare claim number from your child's Medicare Health Insurance Card: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

## D. AUTHORIZATION

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Retiree Signature \_\_\_\_\_ Date \_\_\_\_\_



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Home Address: Street \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Telephone \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Soc. Sec. No. \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Date of Birth \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Sex \_\_\_\_\_  Single  Married  Domestic Partner  Legally Separated/Divorced Date of Marriage \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**MEDICARE:** If eligible, copy the following information from your Medicare Health Insurance Card:

Medicare Claim Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  Over 65  Disabled and under 65

## B. SPOUSE/DOMESTIC PARTNER INFORMATION - Surviving spouse should fill out Section A above.

Name of Spouse/Domestic Partner: Last \_\_\_\_\_ First \_\_\_\_\_ M.I. \_\_\_\_\_

Soc. Sec. No. \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Date of Birth \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**MEDICARE:** If your spouse/domestic partner is eligible, copy the following information from your spouse/domestic partner's Medicare Health Insurance Card:

Medicare Claim Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  Over 65  Disabled and under 65

## C. ENROLLMENT - Directions: For initial enrollment, complete section 1; to disenroll from an HMO, complete section 2; to disenroll from prescription drug coverage, complete section 3; to disenroll from medical coverage, complete section 4; to change enrollment, complete section 5; to enroll dependent(s), complete section 6.

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My dependent child(ren)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Spouse/Domestic Partner's Signature (if Medicare-eligible) \_\_\_\_\_ Date \_\_\_\_\_

Child's Signature (if Medicare-eligible) \_\_\_\_\_ Date \_\_\_\_\_

## DEPENDENT CHILDREN INFORMATION: If you have more than two dependent children, please attach an additional sheet.

First Name	MI	Last Name	Sex		Date of Birth	Handicapped		Social Security Number	Full-Time Student		Name of school if full-time student over age 19
			M	F		Yes	No		Yes	No	

**MEDICARE:** If your handicapped child is eligible, copy the Medicare claim number from your child's Medicare Health Insurance Card: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

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