

Carnegie Mellon Benefits Enrollment/Change Form for Retired Employees

Read the Medical Benefits Workbook for Retired Employees for more information about plans, costs and requirements. **If electing a Medicare HMO, in addition to this form, you must also complete the carrier's enrollment form and send it directly to the carrier.**

Retiree Information			
Please print or type.			
Last Name	First Name	M.I.	Social Security Number
Street Address		Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth - Month/Day/Year
City	State	Zip	Phone

Reason for Change

Changes during the year to medical coverage must be made within 31 days of a qualifying change in family or life status (see options below). No other changes are permitted until the annual Open Enrollment period.

DATE CHANGE OCCURED: _____

<input type="checkbox"/> Open Enrollment / Newly Retired	<input type="checkbox"/> Termination of spouse's/domestic partner's coverage under another plan*
<input type="checkbox"/> Death of spouse/domestic partner*	<input type="checkbox"/> Moving away from the area
<input type="checkbox"/> Marriage*	<input type="checkbox"/> Other: (subject to approval by HR)
<input type="checkbox"/> Domestic Partner relationship established*	_____
<input type="checkbox"/> Divorce*	_____
<input type="checkbox"/> Domestic Partner relationship terminated*	_____
<input type="checkbox"/> Commencement of spouse's/ domestic partner's coverage under another plan	_____

TO BE COMPLETED BY HR:

DATE BENEFITS TO BECOME EFFECTIVE:

On the date of change

1st of month following change

* Documentation required to verify the life/status event change. Contact Human Resources at 412-268-4747 to learn more about the supporting documentation that must be submitted or completed.

Medical Election

<p>I elect the following medical plan:</p> <p><input type="checkbox"/> UPMC for Life Retiree HMO* Group Number MC0144</p> <p><input type="checkbox"/> HealthAmerica Advantra HMO* Group Number 2101881001</p> <p><input type="checkbox"/> Highmark SecurityBlue HMO* Group Number 58426-60 / 58426-70</p> <p><i>* - If electing a Medicare HMO, in addition to this form, you must also complete the carrier's enrollment form and send it directly to the carrier.</i></p> <p><input type="checkbox"/> Highmark Retiree Major Medical and CVS/Caremark Supplemental Prescription Drug Coverage Major Medical Group Number 50387-02 CVS/Caremark Group Number 200227555</p> <p><input type="checkbox"/> Waive medical coverage</p>	<p>I elect the following level of coverage:</p> <p><input type="checkbox"/> Individual</p> <p><input type="checkbox"/> Retiree & Spouse (See dependent information on next page.)</p> <p><input type="checkbox"/> Retiree & Domestic Partner (See dependent information on next page.)</p> <p>Retiree Service:</p> <p><input type="checkbox"/> Retiree with less than 15 years of service</p> <p><input type="checkbox"/> Retiree with 15 or more years of service</p> <p><input type="checkbox"/> Mellon Institute Retiree</p>
---	---

Retiree & Dependent Information

If electing level of coverage that includes spouse/domestic partner, complete this section.

Retiree Are you covered by other medical insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No	If electing HMO, Primary Care Physician Practice Code (not name) required. Note PCP code here: <input type="checkbox"/> Check here if currently a patient of PCP				
<input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner Is this person covered by other medical insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No	Last Name	First Name	MI	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Social Security Number
Activity: <input type="checkbox"/> Add to Medical <input type="checkbox"/> Delete from Medical	Date of Birth (Month/Day/Year)		If electing HMO, Primary Care Physician Practice Code (not name) required. Note PCP code here: <input type="checkbox"/> Check here if currently a patient of PCP		

Retired Employee Signature

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subject such person to criminal and civil penalties. I agree to comply with all provisions and procedures that govern administration of the Benefit Plans for Carnegie Mellon. I understand the university will make the necessary adjustment to my costs based on these changes/elections.

Signature_____
Date

Return to: Carnegie Mellon University, Human Resources Benefits Office, 5000 Forbes Avenue, Pittsburgh, PA 15213. **Questions?** Call (412) 268-2047.

**IF YOU ARE ENROLLING IN A MEDICARE HMO,
BE SURE THAT YOU ALSO COMPLETE THE CARRIER ENROLLMENT KIT AND SEND IT DIRECTLY TO THE CARRIER,
IN ADDITION TO COMPLETING THIS FORM AND RETURNING IT TO THE BENEFITS OFFICE.**