

If you are not making changes to your coverage, you need not complete this form. If you are enrolling in a Medicare HMO plan, you must also complete a separate *carrier enrollment form*.

| 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 30 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 412-268-2047 to learn more about the supporting documentation that must be submitted or completed.

Medical Election

(Note: You must complete the separate carrier enrollment form to be enrolled in a Medicare HMO plan.)

| | |
|---|---|
| <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><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 through Carnegie Mellon</p> | <p>I elect the following level of coverage:</p> <p><input type="checkbox"/> Individual</p> <p><input type="checkbox"/> Retiree & Spouse (See dependent info on page 2.)</p> <p><input type="checkbox"/> Retiree & Domestic Partner (See dependent info on page 2.)</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?

 Yes No**If electing HMO, Primary Care Physician Practice Code (not name) required. Note PCP code here:** Check here if currently a patient of PCP **Spouse** **Domestic Partner**

Is this person covered by other medical insurance?

 Yes No

Last Name

First Name

MI

Sex

 M F

Social Security Number

Activity:

 Add to Medical Delete from Medical

Date of Birth (Month/Day/Year)

If electing HMO, Primary Care Physician Practice Code (not name) required. Note PCP code here: 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, Human Resources–Benefits Office, 5000 Forbes Avenue, Pittsburgh, PA 15213.**Questions?** Contact us at (412) 268-2047.