Kent County Retiree Benefit Election Form

Date of Event: ____ / ____

Effective Date: *(H.R. Use Only)* ____ / ____

Privacy No.: *(H.R. Use Only)* _____

☐ Marriage* ☐ Birth/Adoption* ☐ Medicare Eligible* ☐ Loss of Coverage* ☐ Name/Address Change ☐ Open Enrollment _____ (year)

☐ Divorce* ☐ Add Dependent(s)* ☐ Delete Dependent(s) ☐ Other _____

*Documentation Necessary

Retiree Social Security No.	Retiree Last Name	Retiree First Name	M.I.	Sex	Birthdate	Cell Phone

Home Address	City	State	Zip	Home Phone

List all dependents below

Check One	Last Name	First Name	M.I.	Sex	Date of Birth	Social Security No.	Relationship
Spouse Add ☐ Delete ☐							
Dep-1 Add ☐ Delete ☐							
Dep-2 Add ☐ Delete ☐							
Dep-3 Add ☐ Delete ☐							

Medical Coverage

	AmWINS Transamerica	BCBS PPO	GVHP HMO	Waive Coverage
Retiree	☐	☐	☐	☐
Spouse	☐	☐	☐	☐
Dependent(s)	☐	☐	☐	☐

Grand Valley HMO ***(choose location)***

- ☐ Beckwith 224-1515
- ☐ Jenison 457-3830
- ☐ Rockford 866-9568
- ☐ Walker 784-4717
- ☐ Wyoming 532-1100

Prescription Coverage

	OptumRx	Medicare Generation Rx Basic	Medicare Generation Rx Enhanced	Waive Coverage
Retiree	☐	☐	☐	☐
Spouse	☐	☐	☐	☐
Dependent	☐	☐	☐	☐

Vision Coverage

Vision Service Plan

Single ☐ Double ☐ Family ☐ Waive ☐

Other Coverage - Coordination of Benefits

Do you, your spouse or dependents maintain other coverages? ☐ yes ☐ no If yes, please complete the section below. List all types of other coverage

Type of Coverage Med Rx Vis	Carrier Name	Group / Policy #	Contract Holders Name	Contract No.	Individual(s) Covered Ret. Spouse Dep-1 Dep-2 Dep-3
☐ ☐ ☐					☐ ☐ ☐ ☐ ☐
☐ ☐ ☐					☐ ☐ ☐ ☐ ☐

Other Coverage - Medicare

Are you, your spouse, or dependents Medicare eligible? ☐ yes ☐ no

Last Name	First Name	Medicare Claim #	Part A Effective Date	Part B Effective Date

I understand that the above benefit elections may only be used for me or my dependents as defined under the plan. My benefit elections will remain in effect for the entire plan year, unless I experience a change in my family status. I also understand that I must notify Human Resources within 30 days of the change in my family status in order to change my benefit elections.

Signature: _____ **Date:** _____

Waiver Coverage I wish to waive my medical and prescription benefits. I understand that I will be unable to enroll in health benefits until the next Open Enrollment period unless I experience a change in my family status. I understand that this waiver will become effective the first of the month following receipt of this form by Human Resources. Should I choose to elect coverage during Open Enrollment, my elections will not become effective until January 1st, the beginning of the next plan year.

Signature: _____ **Date:** _____

Rev. 10/14