**CITY OF DETROIT POST-2014 NON-SAFETY EMPLOYEE**

**RETIREE HEALTHCARE TRUST**

**P.O. BOX 1497**

**TROY, MICHIGAN 48099-1497**

**(248) 641-4989**

**Dental / Vision Enrollment Form**

Retired on or after January 1, 2015

**Part I. Retiree Information** (\*required information)

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| \*Last Name |  | \*First Name |  | \*M.I. | \*Sex | \*Social Security Number  |
| \*Street Address |  | Apt No. | \*City | \*State | \*ZIP Code |
| \*Marital Status: Single | Married | Divorced | Widowed |  | \*Date of Birth (MM/DD/YYYY) |
| \*Phone Number and Area Code | Email Address |
| \*Medicare Number | Medicare Part A Effective Date | Medicare Part B Effective Date |
| \*Date Retired (MM/DD/YYYY) |

**Part II. Coverage Selection**: Place an "X" in the box to select your dental and/or vision plan.

|  |  |
| --- | --- |
| **Dental Plan Options**  | **Vision Plan Options**  |
| Golden Dental Plan   Single $27.90  Couple $43.52  Family $63.69 | Heritage Standard Vision Plan Retiree and spouse and/or dependents $ 6.80  Heritage National Vision Plan Retiree $ 6.95  Retiree plus one or more $13.88  |

**Part III. Dependent Information:**

**Relationship to Retiree**

**Last Name, First Name**

**Date of Birth (MM/DD/YY)**

**Sex**

**Social Security Number**

**Medicare Number**

**Medicare Effective Date**

**Dependent Coverage Selection**

**Dental**

**Vision**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Relationship to Retiree****Spouse** | **Dependent Coverage Selection****Dental Vision**  | **Last Name, First Name** | **Date of Birth (MM/DD/YY)** | **Sex** | **Social Security Number** | **Medicare Number** | **Medicare Effective Date** |
| **Spouse** |  |  |  |  |  |  |  |  |
| **Child** |  |  |  |  |  |  |  |  |
| **Child** |  |  |  |  |  |  |  |  |
| **Child** |  |  |  |  |  |  |  |  |

**I DECLINE ALL COVERAGES - Dental and Vision**

Provide the requested information for each dependent that is to be enrolled in the above selected dental and/or vision plans. Be sure to select the box under the column "Dependent Coverage Selection" to indicate which plan(s) the dependent is to be enrolled in. If enrolling a spouse, you must provide a copy of your marriage certificate. (In some instances, we may require that you submit documentation to substantiate Medicare eligibility and/or the legal relationship of the dependent to the retiree.)

**Part IV. Authorization:** I have elected to enroll myself and my listed dependents in the above dental and/or vision plans, and hereby authorize the General Retirement System of the City of Detroit Post-2014 Non-Safety Employee Retiree Healthcare Trust to:

deduct my premium for such plan(s) from my monthly retirement pension check

***Retiree Signature Date***