# City of Phoenix Retiree Open Enrollment Form

**Elections effective 1st of the following month in which the form is received by Benefits Office.**

| ENROLLMENT TYPE | RETIREMENT | PAYMENT OPTION | MEDICAL REIMBURSEMENT |
|---|---|---|---|
| NEW<br>CHANGE<br>WAIVE ALL COVERAGE | GENERAL CITY (COPERS)<br>POLICE<br>FIRE | PENSION DEDUCTION<br>DIRECT PAY (INSUFFICIENT PENSION) | PEHP<br>MERP |

| 1. EMPLOYEE I.D. # | 2. LAST NAME | FIRST NAME | MI | 3. DATE OF BIRTH |
|---|---|---|---|---|
| | | | | |

| 4. PHYSICAL ADDRESS | CITY | STATE | ZIP CODE |
|---|---|---|---|
| | | | |

| 5. MAILING ADDRESS | CITY | STATE | ZIP CODE |
|---|---|---|---|
| | | | |

| 6. PHONE NUMBER | 7. Last 4 SSN | 8. EMAIL |
|---|---|---|
| | | |

## 9. TYPE OF COVERAGE

| Retiree ONLY | Retiree + 1 | Spouse ONLY (SSN required) | Family **AND** Retiree | Family **NO** Retiree |
|---|---|---|---|---|

## 10. NON-MEDICARE MEDICAL PLAN SELECTION

| UNITED HEALTHCARE (UHC) MEDICAL PLAN | ☐ NAVIGATE HMO<br>☐ CATASTROPHIC PLAN<br>☐ CHOICE HSA<br>☐ CHOICE PLUS PPO | **Waive**<br>**No Change** |
|---|---|---|

## 11. DENTAL AND VISION PLAN / 12. TYPE OF COVERAGE

| | 11. DENTAL AND VISION PLAN | | 12. TYPE OF COVERAGE | | | |
|---|---|---|---|---|---|---|
| **DENTAL** | ☐ HMO | ☐ PPO | ☐ Single | ☐ Retiree + 1 | ☐ Family | ☐ Waive No Change |
| **VISION** | ☐ Buy Up Vision Plan | | ☐ Single | ☐ Retiree + 1 | ☐ Family | ☐ Waive No Change |

**13. PLEASE FILL IN THE INFORMATION BELOW WHEN ENROLLING OR ADDING/REMOVING DEPENDENTS.** (USE A BLANK FORM TO ADD ADDITIONAL DEPENDENTS. INCLUDE YOUR NAME AND MARK AS PAGE 2)

| Add or Del | Mark All That Apply | Last Name | First Name | Check Dependent Type | Gender | DOB MM/DD/YYYY | SSN (SSN required for spouse/QDP only coverage) |
|---|---|---|---|---|---|---|---|
| | Medical<br>Dental<br>Vision | | | Child<br>Spouse<br>QDP<br>QDP Dep | | | |
| | Medical<br>Dental<br>Vision | | | Child<br>Spouse<br>QDP<br>QDP Dep | | | |
| | Medical<br>Dental<br>Vision | | | Child<br>Spouse<br>QDP<br>QDP Dep | | | |

- *Dependent verification documents must be received within 31 days of election date.*
- *By signing this form, I attest that myself or my enrolled dependents are not Medicare eligible. It is my responsibility to notify the City of Phoenix Benefits Office if and when I or my enrolled dependents become eligible for Medicare and are therefore no longer eligible for this coverage.*
- *The signature below authorizes the above elections and pension check deductions and VERIFIES MY UNDESTANDING OF THIS INFORMATION.*

14. **Signature:**

15. **Date Signed:**

| Received By: | Date: | Entered By: |
|---|---|---|
| | | |

**Submit this form and dependent verification to:**
Email: benefits.questions@phoenix.gov
Fax: 602-534-2848

**Mail to:** City of Phoenix
Benefits Office 7th Floor
251 W. Washington Street
Phoenix, AZ 85003