INSTRUCTIONS
PLEASE READ CAREFULLY

Please complete this form if you a) are filing for retirement under the Qualified Pension Plan (QPP) and b) are a Tax-Deferred Annuity (TDA) Program participant who wants to defer distribution of your TDA funds past your QPP initial payability date (i.e., the date on which you may begin receiving your QPP retirement allowance).

You must file this form in conjunction with your retirement application, on which you must elect TDA Deferral status in the “TDA Election” section. If you do not file this form, you cannot attain TDA Deferral status; consequently, you would have to elect a method of distribution for your TDA funds as of your QPP initial payability date.

E electing TDA Deferral status means your account may continue to receive interest/investment return, and you will be able to maintain an existing TDA loan, take out a new TDA loan, and manage your TDA investment elections online. These opportunities would not be available to you otherwise.

Retiring members who have an outstanding TDA loan(s) have a choice of how to repay the loan(s) after their retirement date: automatic deductions from their monthly retirement allowance (including advance payments, if applicable) or monthly direct payments to TRS. At any time during repayment, you may change your repayment method for one or more loans by filing a “Request to Change TDA Loan Repayment Method” (code LO105) with TRS.

At any time, you may elect to annuitize your TDA funds or withdraw a portion or all of these funds; however, doing so may affect your TDA Deferral status.

Under TDA Deferral status, distribution of your Post-1986 Funds (TDA contributions and investment returns accumulated after December 31, 1986) must begin as of April 1 of the year after you reach age 70½; distribution of your Pre-1987 Funds (TDA contributions and investment returns accumulated as of December 31, 1986) must begin as of the date on which you reach age 75. These distributions are in accordance with the Required Minimum Distribution (RMD) guidelines established by the Internal Revenue Service (IRS).

For more information about distribution requirements and other features of TDA Deferral status, please consult the TDA Deferral Status brochure and the Required Minimum Distribution for Members brochure.

For your convenience, TRS forms and publications are available on our website. If you require additional assistance, please contact our Member Services Center at 1 (888) 8-NYC-TRS.

In Part A: All information must be provided.

In Part B: You must elect how you want to repay your outstanding TDA loan(s) after your retirement date: automatic deductions from your monthly retirement allowance (including advance payments, if applicable) or monthly direct payments to TRS. If you elect direct payments to TRS, TRS will send you a monthly loan statement and payment voucher, and you would need to send payment by check each month for all of your loans. If you do not elect a repayment method, your loan payments would automatically be deducted from your monthly retirement allowance (including advance payments, if applicable).

In Part C: You must provide the requested information, and sign and date this form in the presence of a notary.

In Part D: You must have your form notarized.
Please read the instructions before completing this form.
(NOTE: Please print in black or blue ink, and initial any changes that you make on this form.)

PART A: All information must be provided.

First Name ___________________________ MI __________ Last Name ___________________________

Permanent Home Address ___________________________ Apt. No. ___________________________

City ___________________________ State _______ Zip Code ___________________________

Social Security Number (last 4 digits only) ____________ TRS Membership Number ____________

Primary Phone Number (Check one: □ Home □ Work □ Mobile)
( ) ( ) ( ) ( ) ( ) ( ) ( )

Alternate Phone Number (Check one: □ Home □ Work □ Mobile)
( ) ( ) ( ) ( ) ( ) ( ) ( )

Please keep your personal information with TRS up to date. We will update our records based on the information you provide above, so do not enter a temporary address; instead, TRS suggests that you consult the U.S. Postal Service about having your mail forwarded on a temporary basis. To register any changes to your permanent address (and/or phone number), please access our website or file a “Member’s Change of Address Form” (code DM13) with TRS.

If you are providing new information above, please indicate the effective date: □ □/□ □/□ □ □ □ □ □.

PART B: Please elect ONE loan repayment method by checking the applicable box below. (See Part B instructions on Page 1.)

□ I elect to repay my outstanding loan(s) through automatic deductions from my monthly retirement allowance (including advance payments, if applicable).

□ I elect to repay my outstanding loan(s) through monthly payments by check submitted to TRS.

PART C: Please read the following statement, provide the requested information, and sign and date in the presence of a notary.

I certify that I have read the Instructions on page 1 of this form, and I hereby elect TDA Deferral status to delay the distribution of my TDA funds past my QPP initial payability date. I am filing this form in conjunction with my retirement application, on which I have also elected TDA Deferral status. I understand that I must file this form prior to my retirement date under the QPP, which will be ___________________________.

MEMBER’S SIGNATURE ___________________________ DATE (MM/DD/YYYY) __________

PART D: TO BE COMPLETED BY A NOTARY (NOTE: Attestation made outside the U.S. must be executed before an American consul.)

State of ___________________________ s.s.:

County of ___________________________

On the _______ day of ___________________________, ________, before me personally appeared the person known to me to be ___________________________, the individual who executed the foregoing instrument and acknowledged to me that (s)he executed the same.

Signature: ___________________________

Official Title: ___________________________

Expiration Date of Commission: ___________________________

TD30 (8/14)
INSTRUCTIONS
PLEASE READ CAREFULLY

Please file this form if you would like to do one of the following:

1) Initiate an Electronic Fund Transfer (EFT) for monthly retirement allowance payments under the Qualified Pension Plan (QPP) and/or annuity payments under the Tax-Deferred Annuity (TDA) Program into a bank checking or savings account; or

2) Change your account number or financial institution for your EFT payments.

EFT Benefits and Eligibility

- EFT allows eligible participants to have their monthly payments electronically transferred to a designated checking or savings account. It is safe, convenient, and automatic.

- Eligible participants include the following:
  - TRS retirees;
  - TRS beneficiaries; and
  - Alternate payees of a TRS retiree or beneficiary under a Qualified Domestic Relations Order (QDRO).

EFT General Provisions

- The financial institution that you choose for EFT must participate in the Automated Clearing House (ACH) program. Please contact your financial institution if you are unsure it participates in this program.

- You must designate either a bank checking or savings account to enroll in EFT. This account may be a single or joint account. Please note that trust accounts, certain money-market accounts, and certain investment companies are not eligible to receive EFT deposits.

- If you elect EFT for more than one type of monthly benefit payment (see Part C), you may file this form to designate the same account number for all payment types indicated. If you elect to designate more than one account number, you must file a separate “EFT Authorization Form” for each account.

- If you receive a Required Minimum Distribution (RMD) from your TDA account, your RMD payment will be automatically sent via EFT to the same account designated for your QPP retirement allowance payments.

- You may cancel your EFT at any time by filing an “EFT Cancellation Request Form” (code BK19) with TRS.

CONTINUED ON PAGE 2
**Filing Your Form**

- Please return your completed form to TRS at the following address:
  Teachers' Retirement System of the City of New York
  Bowling Green Station, PO Box 5005,
  New York, NY 10274

  Upon receipt of your correctly completed form, TRS will send you a confirmation letter. It generally takes 15-45 days from the time that TRS receives this completed form to arrange for your account to be processed for EFT or for your monthly payments to be posted to your new financial institution or account number.

- If you are initiating an EFT: In the interim, you will continue to receive a regular paper check for your monthly payments. Once your EFT is implemented, the City of New York will transmit your funds to your financial institution by the last day of the month for posting to your account. These funds will become available for withdrawal once your financial institution has posted them to your account; this generally occurs the last day of the month, or the first business day of the following month. **Your financial institution, not TRS, controls when payments are posted to your account.**

- If you are changing your financial institution or account number: In the interim, your payments will continue to be electronically transferred to the financial institution or account number currently on file. If you want to maintain your EFT without interruption, do not close your current account until the EFT transition is implemented. If your old account is closed, you will receive your payments by paper check at your home address until this form takes effect.

- Following the implementation of your EFT request, you will receive a quarterly statement, which shows the same information that your monthly benefit payment stub(s) would have provided. This includes a breakdown of your payment, as well as a summary of your deductions (e.g., health insurance, union dues, and federal withholding taxes). The EFT Quarterly Statement will also include any enclosures that are customarily mailed with QPP retirement allowance and TDA annuity checks. (The monthly transactions will also appear on the statements you receive from your financial institution.)

- Please note that, if your financial institution closes or merges with another, or if your account number is modified, your payment cannot be credited, and your EFT would be automatically suspended. TRS would notify you by letter if this occurs, and you would then receive future payments by check at your home address. To reinstate your EFT, you would need to file another “EFT Authorization Form” with updated information about your financial institution.

**Required Documentation**

- When you submit this form, you must provide a letter from your bank (on bank letterhead and signed by a bank officer) indicating the owner(s) of the account, the account and routing numbers, the account type, the branch location, and the branch officer’s contact information.

- Please indicate on this form the following: The name and address of your financial institution, your checking or savings account number, and your financial institution’s ABA (transit/routing) number. The ABA number is usually the first nine digits before the account number in the bottom left corner of your check or deposit slip. (If you do not know the ABA number, please contact your financial institution.)

**Questions and Further Information**

For more information about EFT, please refer to the *Electronic Fund Transfer* brochure. For your convenience, TRS forms and publications are available on our website. If you require additional assistance, please contact TRS’ Member Services Center at 1 (888) 8-NYC-TRS.
EFT AUTHORIZATION FORM

( NOTE: Please print in black or blue ink, and initial any changes that you make on this form. )

PART A: Please provide the information below.

First Name       MI       Last Name

Permanent Home Address   Apt. No.

City             State        Zip Code

Email Address

Social Security Number (last 4 digits only)  [Redacted]

TRS Retirement/Beneficiary Number

Primary Phone Number (Check one: Home     Work     Mobile)

Alternate Phone Number (Check one: Home     Work     Mobile)

☐ Check here if you entered new contact information above. TRS will then update our records based on what you entered.

Please keep your contact information up to date. You can visit our website to update your contact information anytime, or file a "Member’s Change of Address Form" (code DM13) or, if applicable, a "Beneficiary’s Change of Address Form" (code DM14) with TRS.

PART B: Please provide the requested information below, then complete PART C and PART D on page 4. You must enclose a letter from your bank (on bank letterhead and signed by a bank officer) indicating the owner(s) of the account, the account routing numbers, the account type, the branch location, and the branch officer’s contact information.

☐ I would like to initiate an EFT.     ☐ I would like to change my financial institution or account number.

New account information:

Financial Institution

Mailing Address

City             State        Zip Code

Person(s) Named on the Account (Print name exactly as written on the account; include any joint owner.)

ABA (transit/routing) Number

Account Number

Account Type: ☐ Checking     ☐ Savings

Old account information (if applicable):

Financial Institution

Account Number (last 4 digits only): [Redacted]
PART C: Please indicate below the type(s) of payment that you would like deposited or that you are receiving via EFT.

☐ QPP retirement allowance payments
☐ QPP beneficiary payments
☐ QPP DRO payments

☐ TDA annuity payments
☐ TDA beneficiary payments
☐ Other _______________________

PART D: Please read the statement below and sign and date in the presence of a notary. If you are an agent/legal representative signing on the member’s or beneficiary’s behalf, please indicate this.

I hereby authorize the implementation of the instructions indicated on this form to initiate EFT.

I authorize and direct my bank to immediately refund any overpayments to TRS, including all payments made by TRS on or after the date of my death, and to charge the same to my bank account. TRS’ certification of overpayment shall be sufficient evidence of an overpayment. If the funds remaining are not sufficient to permit my bank to fully refund overpayments by TRS, I authorize and direct my bank to provide to TRS all information related to the designated account, including withdrawals after the first of the month in which my death occurs, the names and addresses of all joint account holders and any individuals authorized to withdraw funds from the designated account, and any changes of address within one year prior to the date of my death.

I also understand that this EFT will remain in effect until I request TRS to cancel it. I further understand that if my account is closed, my account number(s) is modified, or my bank closes or merges with another, my EFT would be suspended, and I would need to file another EFT request with updated information to reinstate my EFT. I affirm that, to the best of my knowledge, all information I have provided above is true and correct.

If signing as an agent, I certify that I have no knowledge or notice that my authority as the member’s/beneficiary’s agent has ended by revocation, termination, death, divorce, or otherwise. ☐ CHECK HERE IF YOU ARE SIGNING AS AN AGENT.

YOUR SIGNATURE ___________________________  YOUR PRINTED NAME ___________________________  DATE (MM/DD/YYYY) ___________________________

PLEASE MAIL THIS FORM AND ANY REQUIRED DOCUMENTATION TO TRS AT BOWLING GREEN STATION, PO BOX 5005, NEW YORK, NY 10274.

PART E: TO BE COMPLETED BY A NOTARY (NOTE: Attestation made outside the U.S. must be executed before an American consul.)

State of ___________________________ )

) s.s.:  County of ___________________________

On the ___________ day of ___________, __________, before me personally appeared the person known to me to be ____________________________________________, the individual who executed the foregoing instrument and acknowledged to me that (s)he executed the same.

Signature: ___________________________

Official Title: ___________________________

Expiration Date of Commission: ___________________________

BK58 (9/19)
Health Benefits Program
Application/Change Form
www.nyc.gov/ori

Please print all information clearly using a black or blue ballpoint pen.

**Applicant MUST check one: **
- [ ] EMPLOYEE
- [ ] RETURN TO RETIREMENT (Check this box if you were previously retired)
- [ ] LINE OF DUTY SURVIVOR

**REASON(S) FOR SUBMISSION** (Check one or more boxes. Enter change date, if appropriate)
- [ ] New Enrollment
- [ ] Retirement
- [ ] Disability Retirement
- [ ] Accident Disability Retirement
- [ ] Drop Optional Benefits
- [ ] Reinstatement
- [ ] Waive Benefits

**EMPLOYEES ONLY:**
- [ ] Buy-Out Waiver Program COMPLETE SECTIONS D, E, & F

**Change of:**
- [ ] Spouse/Domestic Partner: [ ] Add [ ] Drop
- [ ] Dependent(s): [ ] Add [ ] Drop
- [ ] Name - Former Name

**For Domestic Partner Changes - Return Form to:**
- [ ] Transfer of Health Plan and/or
- [ ] Optional Benefit Based on:
- [ ] Transfer Period
- [ ] Move In/Out of Health Plan Area
- [ ] Effective Date: __/__/
- [ ] Refers Once-In-A-Lifetime
- [ ] Effective Date: __/__/—

**D. EMPLOYEE/RETIREE INFORMATION**

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>M.I.</th>
<th>Social Security Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home Address:</td>
<td>APL:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>City:</td>
<td>Date:</td>
<td>Zip Code:</td>
<td>Country (if outside the U.S.):</td>
</tr>
<tr>
<td>Date of Birth:</td>
<td>Sex:</td>
<td>Work - Telephone Number:</td>
<td>Mobile/Home - Telephone Number:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>( ) -</td>
<td>( ) -</td>
</tr>
<tr>
<td>Mental Status:</td>
<td>Single Married Divorced Widowed Domestic Partnership:</td>
<td>Date of Event (sick/inj):</td>
<td>Agency in which employed or retired from:</td>
</tr>
<tr>
<td>Name of current City Health Plan:</td>
<td>Are you Medicare eligible: [ ] Yes [ ] No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If Yes, please attach a copy of your Medicare card to this application.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**ATTACH COPY OF CARD**

**E. SPOUSE/DOMESTIC PARTNER - ONLY COMPLETE IF YOUR SPOUSE/DOMESTIC PARTNER IS TO BE COVERED. IF NOT, LEAVE BLANK.**

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>M.I.</th>
<th>Social Security Number</th>
<th>Date of Birth:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sex:</td>
<td>Is Spouse/Domestic Partner:</td>
<td>Employee (Double City coverage is not permitted):</td>
<td>Retired (Double City coverage is not permitted):</td>
<td></td>
</tr>
<tr>
<td></td>
<td>[ ] Yes [ ] No</td>
<td>[ ] City Agency Name:</td>
<td>[ ] Not Employee</td>
<td></td>
</tr>
<tr>
<td>Does spouse/domestic partner have Non-City group health plan?:</td>
<td>Is your spouse/domestic partner Medicare eligible: [ ] Yes [ ] No</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If Yes, please attach a copy of his/her Medicare card to this application.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**ATTACH COPY OF CARD**

**F. FAMILY INFORMATION** (Attach a second form if necessary; dependent may not be covered under two NYC Health Plans.)

<table>
<thead>
<tr>
<th>Dependent's Last Name</th>
<th>Dependent's First Name</th>
<th>Date of Birth</th>
<th>Social Security Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dependents' gender:</td>
<td>[ ] Male [ ] Female</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Attach a copy of Medicare card if dependent is Medicare eligible.**

**G. HEALTH PLAN REQUESTED** (Please print clearly)

**FULL NAME OF HEALTH PLAN SELECTED:**

Optional Benefits? (Check "Yes" or "No" for optional benefits rider. If no box is checked, it will be presumed that you do not want optional benefits.) [ ] Yes [ ] No

**H. EMPLOYEES ONLY (RETIREEs ARE INELIGIBLE FOR THE HEALTH BENEFITS BUY-OUT WAIVER PROGRAM)**

I wish to participate in the Health Benefits Buy-Out Waiver Program. I have read the Medical Spending Conversion Health Benefits Buy-Out Waiver Program brochure and completed a Medical Spending Conversion Form and I attest that I meet the qualifications for this program. (Retirees, Line of Duty Survivors and CNUY Adjusted employees are not eligible.)

Employee Signature: Date:

**I. TO PARTICIPATE IN THE HEALTH BENEFITS PROGRAM OR REQUEST CHANGES TO HEALTH COVERAGE**

I certify that the above information is correct and I authorize the City to deduct from my salary/pension the amount required, if any, through the City Health Benefits Program.

I understand that the City Program's benefits will be coordinated with those available through Medicare or any other source.

Furthermore, I agree that any periodic health plan deductions, if any, will be made on a pre-tax basis pursuant to the Internal Revenue Code 125. I understand that I have an option to decline this benefit, by obtaining a Medical Spending Conversion Form, both of which are obtainable at my payroll office. (Section 125 does not apply to retirees.)

If I have checked the Waive Benefits Box in Section A, I am choosing not to participate in the City Health Benefits Program at this time.

Employee/Retiree Signature: Date:

**J. FOR COMPLETION BY PAYROLL OR PERSONNEL OFFICE ONLY**

I certify that the above employee/retiree is eligible for the New York City Health Benefits Program (HBP) and that dependent documentation has been verified in accordance with HBP procedures. I certify that the above employee is eligible for the Health Benefits Buy-Out Waiver Program and I have reviewed and processed the Medical Spending Conversion Buy-Out Spending Form and I attest that the employee meets the qualifications for this Program.

Agency Code: | Title Code No.: | Status: | Appointment/Retirement Date: | Pay Period: | Effective Date of Coverage: |
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Retirement System (For Retiring Employees):

<table>
<thead>
<tr>
<th>Years of Credited Service:</th>
<th>City Start Date:</th>
<th>Retirement Date:</th>
<th>Pension Number:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Certifying Signature: Date: Telephone Number: ( )—
Instructions for Completing a Health Benefits Application/Change Form

Section A: If you are a NEW retiree, you should only select from the following: Retirement, Disability Retirement, Accident Disability Retirement or Waive Benefits.

If you are already covered as a retiree, you should only select from the following: Drop/Add Optional Benefits, Waive Benefits (if you wish to cancel your City coverage) and Reinstatement (if you are requesting to reinstate your City coverage after having previously waived coverage).

Section B: Check Spouse/Domestic Partner Information (Add/Drop) if you are adding or dropping a spouse/domestic partner.

If your spouse/domestic partner is deceased, you must attach a copy of the death certificate. If you are dropping your spouse as a result of a divorce, you must attach a copy of the divorce decree.

If you are adding a spouse, domestic partner or dependent child(ren) please refer to the SPD or the Dependent Eligibility Required Documentation instructions on our Web site, at nyc.gov/hbp, for a list of all dependent eligibility documentation requirements for health benefits coverage for dependents.

Check Dependent Child(ren) Add or Drop if you are adding or dropping a dependent child.

If you are adding a dependent child, you must attach a copy of either the birth certificate, or documents proving guardianship or adoption.

If changing your name, please indicate your former name and provide documentation of name change.

Section C: Check Transfer Period if the change you are requesting (such as Adding Optional Benefits or Changing Plans) is being made during a Transfer Period.

Check Permanent Move Into/Out of Health Plan Area if you are requesting to change plans as a result of either moving out of the service area of your current plan, or if you are moving into the service area of another plan.

Check Retiree Once in a Lifetime if you are requesting to change plans or add optional benefits anytime other than a transfer period.

Section D: If you are enrolled in Medicare Parts A & B, you must attach a photocopy of your Medicare card.

Section E: If you are married or have a domestic partner, this section must be completed only if you are covering your spouse/domestic partner.

If your spouse/domestic partner is enrolled in health plan other than your City coverage or Medicare, you must indicate so.

If your spouse/domestic partner is enrolled in Medicare Parts A & B, you must attach a photocopy of his/her Medicare card.

Section F: List ALL eligible dependent children to be covered. If a dependent child is permanently disabled, and on Medicare, you must attach a photocopy of his/her Medicare card. (CUNY ADJUNCT EMPLOYEES: City rates apply for Individual coverage ONLY. Contact your Benefits Office for information about additional cost for Family coverage.)

Section G: Write the complete name of your current health plan or the plan you are selecting (see back of sheet). If you do not make an optional rider selection, you will be given basic coverage only.

Section H: This section is for employees only who wish to participate in the Buy-Out Waiver Program. Remember to date your form. Retirees, Line of Duty Survivors and CUNY Adjunct employees are not eligible for the Buy-Out Waiver Program.

Section I: Your signature is required in this section to enroll or effect the changes requested on this Application/Change Form.

Section J: If you are a NEW retiree (even if you are waiving City coverage), your payroll/personnel office must complete this section.

See top, right-hand corner of reverse side for instructions on submitting this Application/Change Form. Retain a copy for your records.
Health Plans Available to
Employees, Non-Medicare Retirees and their Dependents

Aetna EPO
Cigna HealthCare
DC 37 Med-Team (DC 37 members only)
Empire EPO
Empire Blue Access Gated EPO
GHI-CBP/Empire BlueCross BlueShield
GHI HMO
HIP Prime HMO
HIP Prime POS
MetroPlus Gold
Vytra Health Plans

RESTRICTIONS: Some health plans are only available in certain states and counties. Please check the Summary Program Description booklet at www.nyc.gov/olr or call the health plans directly.

Health Plans Available to
Medicare-Eligible Retirees and their Dependents

Aetna Medicare PPO ESA Plan*
AvMed Medicare HMO* (Florida only)
Cigna HealthSpring Preferred with Rx (HMO)* (Arizona only)
DC 37 Med-Team Senior Plan (DC 37 Members Only)
Elderplan*
Empire Medicare Related Coverage
Empire MediBlue Freedom (PPO)*
GHI/Empire BlueCross BlueShield Senior Care
GHI HMO Medicare Senior Supplement
HIP VIP Premier (HMO) Medicare Plan*
Humana Gold Plus (certain counties in Florida)*
UnitedHealthcare Group Medicare Advantage Plan*

RESTRICTIONS: Some health plans are only available in certain states and counties. Please check the Summary Program Description booklet at www.nyc.gov/olr or call the health plans directly.

* Medicare eligible retirees who wish to enroll in these plans must enroll DIRECTLY with the health plan. Please verify with the health plan of your choice whether or not you reside in its service area. Do not use this form for enrollment in these plans.