CITY OF WEST ALLIS HUMAN RESOURCES

RETIREE OPTION 1 HEALTH PLAN APPLICATION

FORM HR-1

Instructions

Complete this form by January 15, 2022, if you wish to enroll in the Option 1 Health Plan for Retirees. Option 1 allows for a reduced monthly premium, along with other plan design changes. Option 1 is not available to those who retired under the Total Benefits Package. For details, contact Human Resources.

1. Retiree Personal Information

Full Legal Name (Last, First, Middle Initial)

Street Address

City | County | State | ZIP

Home Phone Number ( ) - New phone number? ☐ No ☐ Yes

Cell Phone Number ( ) - New phone number? ☐ No ☐ Yes

Email

Current Health Plan Coverage Level:

☐ Single ☐ Married ☐ Family

2. Medicare, Medicaid, Title 19

Is anyone currently on your plan (including you) covered by Medicare, Medicaid, or Title 19?

☐ No - Skip to Section 3 (“Benefit Options”)

☐ Yes - Complete the following information:

Full Legal Name Last, First, Middle Initial	Reason for Coverage	Type	Card No.	Effective Date For Medicare, list Part A & B Effective Dates
	☐ 65 or older ☐ Disabled ☐ Other	☐ Medicare ☐ Medicaid ☐ Title 19		
	☐ 65 or older ☐ Disabled ☐ Other	☐ Medicare ☐ Medicaid ☐ Title 19		
	☐ 65 or older ☐ Disabled ☐ Other	☐ Medicare ☐ Medicaid ☐ Title 19		
	☐ 65 or older ☐ Disabled ☐ Other	☐ Medicare ☐ Medicaid ☐ Title 19		

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3. Benefit Options

☐ I wish to enroll in the City's Option 1 Health Plan with a premium of $_____ for the 2022-23 plan year.

You must initial each of the following items confirming your understanding:

_____ I understand that my premium cap remains the same as when I retired. *(Human Resources insert cap number here: $_____)*

_____ I understand that, starting in the 2022-23 plan year, my benefit levels and premium share percentage will be the same as active employees.

_____ I understand that by choosing this option, my eligibility to participate in any City health insurance program (other than a Medicare Advantage program, if any) ends at age 65 or when I become Medicare eligible, whichever comes first.

_____ I understand that if the City offers a Medicare Advantage program, my eligibility for coverage with the city has ceased, and I (and my spouse, if applicable) am eligible for the Medicare Advantage program, I may participate at my full cost.

_____ I understand that by choosing this option, my family coverage will be limited to 12 years or age 65, whichever comes first.

_____ I understand that if the City offers voluntary benefits (dental, vision, etc.), I will be eligible to participate at my full cost until I reach age 65 or when I become Medicare eligible, whichever comes first.

_____ I understand the City is offering qualified retirees the option to participate in the Family Savings Plan with Network Health, but I choose not to participate.

Dental Insurance (see Employee Benefits Guide for details)

☐ I decline dental coverage

☐ I wish to participate in the CarePlus Dental Plan at my full cost
*(Single Plan: **$35.96** per month; Couple/Family: **$110.62** per month)*

Vision Insurance (see Employee Benefits Guide for details)

☐ I decline vision coverage

☐ I wish to participate in the Superior Vision Plan at my full cost
*(Single Plan: **$5.95** per month; Couple/Family: **$16.21** per month)*

COBRA Notice: In accordance with the Consolidated Omnibus Reconciliation Act (COBRA), and subject to the terms stated in your Summary Plan description, CONTINUATION of medical and/or dental benefits may be available for you and/or your covered spouse/dependents upon termination of coverage. You will receive information regarding COBRA continuation coverage (including premium costs) upon your (and/or your spouse/dependents) termination of coverage under this plan.

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4. Terms & Conditions

You must initial each of the following items confirming your understanding:

☐ I understand that all information I have received pertaining to my benefits is based on certain estimates and assumption; I understand that the City retains the right to change benefit offerings and reserves the right to correct any inaccuracies.

☐ I understand the decision I am making regarding my benefits; I understand that enrollment in Option 1 is a one-time choice, and I will not be given an opportunity to move back to my original plan and its benefit levels.

☐ I authorize the City to obtain any information from any source necessary to administer this insurance.

☐ I agree to pay the current premium for this insurance, and I authorize the City to collect an amount sufficient to provide for regular monthly premium payments through direct debit or other arrangement as provided by the Finance Department.

☐ I understand that, as defined under 2011 Wisconsin Act 32, children may be covered on an employer's health and/or dental plan(s) to age 26 and that coverage may be provided to children age 26 and older if certain requirements are met.

☐ I understand that it is my responsibility to notify Human Resources within 30 days of a qualifying event (change) effecting my coverage, including: marriage, birth, adoption, death, divorce, Medicare/Medicaid/Title 19 eligibility, address change, etc.

☐ I understand that failure to provide timely notice of a qualifying event may result in loss of coverage, delay in payment of claims, loss of continuation rights and/or liability for claims/premiums paid in error; Upon request, I agree to provide any documentation the City deems necessary to substantiate my eligibility or that of my spouse/dependents.

☐ I understand that if I decline enrollment in a City plan for myself or my spouse/dependents because of other health insurance coverage, I may be able to enroll myself and my spouse/dependents in this plan if I or my spouse/dependents suffer a hardship (such as loss of other coverage); However, I must request enrollment within 30 days of the other coverage end date and provide proof of loss and any required documentation necessary to join the plan.

☐ I agree to abide by the terms of my benefit plan, as explained in any written materials I receive from the City or its third party administrator (Anthem), including the Employee Benefit Guide.

To the best of my knowledge and belief, all statements and answers in this application are complete and true. I understand that if I provide false or fraudulent information on this application, I may face criminal charges/sanctions, reductions or denials of claims, and/or other disciplinary action which may include termination of coverage under this plan.

Retiree Signature

Date