Department of Human Resources
Division of Employee Benefits

2023 Open Enrollment - Retiree Enrollment Form

Use this enrollment form to *CHANGE* or *DECLINE* your medical insurance for the 2022 plan year.

Retiree Information

Name (Please Print)	**Social Security Number**
Street Address (No PO Boxes) **City, State, Zip Code**	
Phone Number:	**Date of Birth**

Medical Insurance Election

☐ **UHC Medicare Advantage Plan**

(Automatic Enrollment for Medicare Eligible Retirees, Spouses, and Dependent Children)

☐ Retiree (Enrolled in Medicare) ☐ Retiree and Spouse (Enrolled in Medicare)

☐ Spouse (Enrolled in Medicare) ☐ Dependent Child (Must be enrolled in Medicare)

☐ **UHC Choice Plus Plan**

(Enrollment only for Non-Medicare Eligible Retirees, Spouse, and Dependent Children)

☐ Retiree ☐ Spouse ☐ Retiree and Spouse ☐ Family

☐ Children Only ☐ Retiree + Child(ren) ☐ Spouse + Child(ren)

☐ **Waive** - If you elect to waive coverage at this time, you will **Not** be eligible to re-enroll at a later date

Milwaukee County Benefit Division
901 N. 9th Street, Room 210, Milwaukee, WI 53233
Benefits@MilwaukeeCountywi.gov | Phone (414) 278-4198 | Fax (414) 223-1379

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Medicare Information

Are you or any member of your family eligible for Medicare? ☐ Yes ☐ No
If Yes, please complete the following for each Medicare eligible member

Name of Person Covered by Medicare:		
Medicare ID Number (REQUIRED):	**Medicare Part A Effective Date:**	**Medicare Part B Effective Date:**
Name of Person Covered by Medicare:		
Medicare ID Number (REQUIRED):	**Medicare Part A Effective Date:**	**Medicare Part B Effective Date:**

Dependent Information

As of January 1, 2011, the Centers for Medicare & Medicaid Services (CMS), a federal government agency, require eligibility data sent to UnitedHealthcare to include social security numbers of all individuals covered under any Milwaukee County medical plan. Please include the social security number for all covered dependents. Please list demographic information with entire Social Security Number for all dependents.

Your Medical Dependents

Full Name	Date of Birth	Social Security Number (Required)	Relationship	Gender
			☐ Spouse ☐ Child	☐ Male ☐ Female
			☐ Spouse ☐ Child	☐ Male ☐ Female
			☐ Spouse ☐ Child	☐ Male ☐ Female
			☐ Spouse ☐ Child	☐ Male ☐ Female
			☐ Spouse ☐ Child	☐ Male ☐ Female

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Milwaukee County Group Life Insurance

Update or Cancel your coverage

☐ **Waive:** If you elect to waive coverage at this time, you will ***NOT*** be eligible to re-enroll at a late date

Life Insurance Beneficiary

If you are electing Group Life Insurance, please enter your beneficiaries below.

Full Name	Date of Birth	Relationship	Share (%)	Primary or Contingent

I am confirming that all information is represented accurately, and that dependent/s listed on my record are eligible for coverage under the terms of Milwaukee County's benefit plans. I understand I may be required to provide verification of all information contained within my enrollment record.

Signature of Applicant:	Date: