



Department of Human Resources
Division of Employee Benefits

2026 Retiree Change Form

Please read this entire form carefully and check all boxes that apply. Not valid unless signed. You may not waive coverage for yourself and request coverage for a spouse and /or child(ren).

Retiree Information

Form section for Retiree Information with fields: Name (Please Print), Social Security Number, Date of Birth, Street Address (No PO Boxes), Phone Number, City, State, Zip Code, Email Address.

Reason For Change

Form section for Reason For Change with options: Waive / Cancel Coverage (Health Insurance, Life Insurance), Marriage or Divorce, Birth or Adoption.

Medical Insurance Election

Form section for Medical Insurance Election with options: UHC Medicare Advantage Plan, UHC Choice Plus Plan, Waive.



Department of Human Resources
 Division of Employee Benefits

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
			<input type="checkbox"/> Spouse <input type="checkbox"/> Child	<input type="checkbox"/> Male <input type="checkbox"/> Female
			<input type="checkbox"/> Spouse <input type="checkbox"/> Child	<input type="checkbox"/> Male <input type="checkbox"/> Female
			<input type="checkbox"/> Spouse <input type="checkbox"/> Child	<input type="checkbox"/> Male <input type="checkbox"/> Female
			<input type="checkbox"/> Spouse <input type="checkbox"/> Child	<input type="checkbox"/> Male <input type="checkbox"/> Female
			<input type="checkbox"/> Spouse <input type="checkbox"/> Child	<input type="checkbox"/> Male <input type="checkbox"/> Female



Department of Human Resources
 Division of Employee Benefits

Group Life Insurance

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

Life Insurance Beneficiary Changes (if applicable)

If you need to change your Beneficiary information, please enter 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: