***Department of Human Resources***

Division of Employee Benefits

# 2027 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

| **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

☐ **Waive / Cancel Coverage**
☐ Health Insurance ☐ Life Insurance
Date Effective:
[ ] Enroll in Medical
[ ] Remove Dependent:_____

☐ **Marriage or Divorce**
Date of Marriage/Divorce:

☐ **Birth or Adoption**
Date of Birth/Adoption:

## Medical Insurance Election

☐ **UHC Medicare Advantage Plan**

☐ 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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# Group Life Insurance

☐ **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 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:** |
|---|---|
| | |

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