COLUMBIA UNIVERSITY
HR Benefits

Medical Plan Election Form for Retired Support Staff

Please complete this form, then sign and date. **Enrollment Effective 1/1/2021**	**Fax, mail or email this form to:** Columbia University 622 W. 132nd Street, 4th Floor New York, NY 10027 Fax: 212-851-7025 **email**: hrbenefits@columbia.edu

Last Name:		**First Name:**	
CU ID number or UNI:		**Date of Birth:**	– –
Mailing Address:			
Telephone Number:	– –	**Retirement Date:**	– –

I elect the Empire BlueCross BlueShield Medical Plan for:

☐	**Non-Union Support Staff/ 2110/ TWU**	☐	**I wish to waive/ terminate coverage. I understand that if I waive coverage, I permanently forfeit my eligibility for retiree medical coverage.**
☐	**SSA/32BJ**		

COVERAGE LEVEL: **Please check all boxes that apply**	☐ **Myself**	☐ **Spouse/Same-Sex Domestic Partner**
	☐ **Dependent Child(ren)**	☐ **Surviving Dependent of Retired S.Staff**

Dependent Information

Only the spouse/same-sex domestic partner named as your dependent when you retired will be eligible for medical benefits when you retire. However, you may add new dependent children to your coverage. Dependent children can be covered until age 19, or until age 26 if a full-time student. Enter information for all dependents you will cover. You must provide proof of each dependent's eligibility if selected for an audit.

If you are currently enrolled in same-sex domestic partner coverage and you enroll in benefits for 2021, you will continue to receive same-sex domestic partner benefits. Beginning January 1, 2021, new enrollees will not have the option of same-sex domestic partner coverage.

Dependent #1: Name:				
Social Security Number:	Call Benefits Service Center	**Relationship:**	**Date of Birth:**	– –
Dependent #2: Name:				
Social Security Number:	Call Benefits Service Center	**Relationship:**	**Date of Birth:**	– –
Dependent #3: Name:				
Social Security Number:	Call Benefits Service Center	**Relationship:**	**Date of Birth:**	– –

I understand that when I and any of my dependents become eligible for Medicare, we must enroll in Medicare Part A and Part B as our primary insurer. I understand that if I waive my Columbia University Retiree Medical Coverage at this time, future eligibility will be determined upon the terms of the retiree medical plan in effect at the time.

Retiree Signature: _____ ***Date (mm/dd/yyyy):*** _____