COLUMBIA UNIVERSITY
HR Benefits

# 2017 Health Plan Election Form for Support Staff Retirees

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| **Please print all information and sign and date the form.**<br>⊗ **Open Enrollment**<br>⊗ **New Enrollment, Effective : _____**<br>⊗ **Qualified Life Status Change**<br>**[ ] Add dependent effective: _____**<br>**[ ] Drop dependent effective: _____**<br>**[ ] Terminate Plan effective: _____** | **Fax or mail this form to:**<br>**Columbia University**<br>**615 West 131st Street, 4th Floor**<br>**New York, NY 100127**<br>**Fax: 212 851-7025**<br>**e-mail: 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 Blue Cross & Blue Shield Medical Plan for:

| | | | |
|---|---|---|---|
| ⊗ | **Non-Union Support Staff/ 2110/ TWU** | ⊗ | **I waive/ terminate coverage at this time** |
| ⊗ | **SSA/32BJ** | | *I understand that I may waive coverage for up to five years from my retirement date. After this period, if I am not enrolled, or choose to terminate the plan, I will permanently forfeit my eligibility.* |

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|---|---|---|
| **COVERAGE LEVEL:**<br>**Please check all boxes that apply** | ⊗ **Yourself** | ⊗ **Spouse/Domestic Partner** |
| | ⊗ **Dependent Child(ren)** | ⊗ **Surviving Dependent of University Retiree** |

## Dependent Information

**Please Note: Only the spouse/same-sex domestic partner who was your dependent when you retired will be eligible for medical benefits after you retire. However, you may continue to add new dependent children to your coverage. Eligible children are those who are under age 19, or if a full-time student, under age 26. Enter information for all dependents you will cover. You must be prepared to provide proof of each dependent's eligibility if you are selected for an audit.**

| | | | | |
|---|---|---|---|---|
| **Dependent #1: Name:** | | | | |
| **Social Security Number:** | – – | **Relationship:** | **Date of Birth:** | – – |
| **Dependent #2: Name:** | | | | |
| **Social Security Number:** | – – | **Relationship:** | **Date of Birth:** | – – |
| **Dependent #3: Name:** | | | | |
| **Social Security Number:** | – – | **Relationship:** | **Date of Birth:** | – – |

***I understand that when I and any 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):*** _____