COLUMBIA UNIVERSITY
HR Benefits

Medical Plan Election Form for Retired Officers

Please complete this form, then sign and date.

Enrollment Effective 1/1/2023

Mail or fax this form to:
EBPA
37 Industrial Drive
Exeter, NH 03833-4593

Secure Fax: (603) 773-4410

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

Pre-65 Medical Plan Options

☐ **Choice Plus 80**

☐ **Choice Plus 90**

☐ **Choice Plus 100**

COVERAGE LEVEL: **Please check all boxes that apply to the Pre-65 Medical Plan elected**

☐ **Yourself**

☐ **Spouse/Same-Sex Domestic Partner***

☐ **Dependent Child(ren)**

☐ **Surviving Dependent of University Retiree**

☐ **I elect to decline coverage at this time, effective: ______________________________**

By declining I permanently forfeit my eligibility.

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 2023, you will continue to receive same-sex domestic partner benefits. Beginning January 1, 2023, new enrollees will not have the option of same-sex domestic partner coverage.

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