



# Benefits Enrollment Form

# 2015 OPEN ENROLLMENT RETIREE/COBRA - HEALTH ONLY

City of Duluth - Human Resources  
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Benefits Effective Date: 01/01/2015

## SECTION A: ENROLLEE INFORMATION

Full Name: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Email Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

**If you or a dependent turn 65, you will receive a packet from HealthPartners which must be completed to maintain coverage.** In order to maintain your coverage post 65, you will need to apply for Medicare Parts A and B, and complete the HealthPartners Freedom/National Plan application which will be sent to you directly from HealthPartners. Failure to complete all steps will result in a lapse of coverage. . If you or a dependent become Medicare eligible before age 65, please notify City of Duluth Human Resources.

**Gender:**  
 Female  
 Male

**Marital Status:**  
 Single  
 Married  
 Widowed  
 Legally Separated

**Organization:**  
 City of Duluth  
 DECC  
 Duluth Airport  
 HRA

## SECTION B: HEALTH PLAN ELECTION - Comprehensive Hospital / Medical Benefit Plan 3A

Coverage Election:  Single  Family

## SECTION C: DEPENDENT INFORMATION

If you wish to add or cancel dependent coverage, complete this section. Refer to dependent eligibility specifications listed in your Open Enrollment Guide.

Full Name of Dependent	Social Security No.	Date of Birth	Gender	Relationship to Retiree	Health Coverage
					<input type="checkbox"/> Add <input type="checkbox"/> Cancel
					<input type="checkbox"/> Add <input type="checkbox"/> Cancel
					<input type="checkbox"/> Add <input type="checkbox"/> Cancel
					<input type="checkbox"/> Add <input type="checkbox"/> Cancel
					<input type="checkbox"/> Add <input type="checkbox"/> Cancel

## SECTION D: ADDITIONAL INSURANCE INFORMATION - MEDICARE, MEDICAID OR OTHER COVERAGE

If you or any dependents listed above are eligible for Medicare, Medicaid, and/or other insurance, complete this section and attach a copy of the card(s)

Full Name of Insured	Coverage Type (Medicare, Medicaid, or other insurance)	Policy Number	Medicare Effective Date(s)	
			Part A	Part B

## SECTION E: AUTHORIZATION AND SIGNATURE

I hereby certify by my signature on the enrollment form that the foregoing information provided by me is true and correct, and that I have read and accept the conditions described in the enrollment material. I acknowledge having read the information provided to me and agree to all of the terms as defined by the plans I have selected, and I authorize the required deduction (if any) from my wages. By signing this form, I attest that I have reviewed the dependent eligibility requirements and that the information I am submitting is true and accurate. I understand that providing false information or omission of relevant information on this form may result in the denial of claims, cancellation or rescission of coverage, and the City of Duluth or Duluth Joint Powers Enterprise Trust may be required to take action to recover funds expended due to fraud or fiscal misconduct. I also understand that it is my duty to notify the City of Duluth Human Resources Office of any changes provided by me on this form, including changes to the eligibility status of my dependents.

Signature \_\_\_\_\_ Date \_\_\_\_\_