2024 Retiree Medical Benefit Election/Change Form

Retiree Name (Last, First, M.I.)	Employee ID # □FP □ GE	Effective Date of Coverage/Change
Phone Number	Email Address	
Mailing Address	Medicare Number (attach copy of Medicare card) Effective Date Part A Effective Date Part B	
Current Coverage	Type of Change: □ Add Coverage/Dependent(s) □ Remove Dependent(s)/Cancel Coverage	

I ELECT THE FOLLOWING BENEFITS: (Monthly Rates)

Non-Medicare- United Healthcare	**Medicare Advantage- Humana**	
□ **City Plan with HRA** □ Single ($1,059.00) □ Family ($2,105.00)	□ **PPO** □ Single ($47.39) □ Family ($94.78)	□ **Waive/Cancel Coverage**
□ **Simple Wellness Plan** □ Single ($1,104.00) □Family ($2,191.00)	□ **NPPO** □ Single ($86.38) □ Family ($172.76)	

COVERED DEPENDENTS (Add or Remove Individual)

Last Name, First Name, MI	Relationship	Gender	Date of Birth	Social Security #	Medical: □ Add □ Remove
				Medicare number (attach copy of card)	Medicare Effective Date Part A Part B
				Social Security #	Medical: □ Add □ Remove
				Social Security #	Medical: □ Add □ Remove

Carefully read the statement below before signing this form

I hereby authorize the City of Tampa to make the changes listed above and adjust my pension accordingly. I understand that should circumstances change regarding my dependents and/or the availability of other health coverage during the plan year, I am obligated to notify Human Resources within thirty one (31) days of the change of circumstances and to immediately assume any monetary obligations that arise because of the change of circumstances. I understand that a deliberate misrepresentation or misstatement of the facts contained on this form may result in termination of medical coverage. I verify and certify that the information provided on this form is true and correct.

_____ _____

Retiree Signature Date

Administrative Use Only

Effective Date:	Sent to Pension: ISI: Parameter:	Oracle:	Provider: