Washington University in St. Louis

Retiree Benefits Enrollment/Change Form

Submit completed form to:
Washington University Benefits Dept
7509 Forsyth Blvd., Suite 150
St. Louis, MO 63105
or Fax to: (314) 935-8198 (Danforth)
(314) 362-2500 (Med School)

(A) PERSONAL INFORMATION

Last Name	First Name	MI	WUSTL ID or Social Security No. (Required)

Street Address	City	State	Zip	Home Phone No.

University Status: ❑ Retiree ❑ Surviving Spouse

(B) ENROLLMENT CHANGE: Enrollment/changes are effective the first of the month following the date of event

Reason For Enrollment/Change: ❑ **New Retiree** ❑ **Life Event (Check One)** Date of Event ______________

- ❑ Birth or Adoption
- ❑ Change of Employment Status
- ❑ Death
- ❑ Dependent No Longer Eligible
- ❑ Divorce/Legal Separation
- ❑ Loss of other coverage
- ❑ Marriage
- ❑ Spouse's Open Enrollment
- ❑ Termination/Commencement of Employment

(C) HEALTH INSURANCE

I Elect To:

- ❑ Enroll in Health/Dental
- ❑ Enroll in Dental Only
- ❑ Change Plan or Coverage Level
- ❑ Terminate All Coverage

Reason: ________________

Plan Type:

- ❑ Medicare Supplement
- ❑ Pre-65 PPO

Coverage Level:

- ❑ Individual Over 65
- ❑ Individual + Spouse/Partner Over 65
- ❑ Individual Under 65
- ❑ Individual + 1 Dependent Under 65
- ❑ Individual + Spouse/Partner, One Over & One Under 65
- ❑ Individual + 2 or more, Under 65

❑ **Enroll in Vision Buy Up Option** — **You must be enrolled in a health plan to elect the Vision Buy Up** — ❑ **Cancel Vision Buy Up Option**

(D) DEPENDENT INFORMATION Complete only if adding or deleting dependents. Please list covered dependents only

Action	Relationship	Date of Birth	Name Last (if different), First, MI	Gender	Is Dependent Enrolled in Medicare?
❑ Add ❑ Delete	❑ Spouse ❑ Domestic Partner	___/___/___	**NAME** **SSN**	❑ Male ❑ Female	❑ Yes ❑ No
❑ Add ❑ Delete	Child-1	___/___/___	**NAME** **SSN**	❑ Male ❑ Female	❑ Yes ❑ No

(E) MEDICARE INFORMATION List those enrolled in the Medicare Supplement plan.

Name	Effective Date(s)	Medicare Number
	Part A / Part B: ________/_________	
	Part A / Part B: ________/__________	

(F) AUTHORIZATION

My signature below indicates that I have received, read and understand the materials describing the options available to me. I hereby certify that all the information provided is true and correct to the best of my knowledge. I realize that I am making a binding election for the coming calendar year, which can only be changed if I experience a family status change.

SIGNATURE: ____ **DATE:** ________________________

HUMAN RESOURCES USE ONLY Entered by Date Entered Effective Date