

2027 Retiree Benefit Election

Effective Date ____/____/____

☐

Retirement

☐

Open Enrollment

☐

Change

Retiree Name

(Print)

Last

First

Middle Initial

SSN

- -

Spouse Name

(Print)

Last

First

Middle Initial

SSN

- -

Mailing Address

Street

City

State

ZIP Code

Phone

() -

E-mail Address:

Medicare Eligible?

Retiree:

☐

YES

☐

NO

Spouse:

☐

YES

☐

NO

If YES, enrolled retiree/spouse may continue medical coverage by selecting the Medicare Eligible Medical Plan. For Medicare Eligible Medical Plan coverage, retiree/spouse must be enrolled in Medicare Part A and Part B

Medical Insurance

☐ Waive All Medical

☐ No Change

☐ Not Enrolled

Retiree
Only

Spouse
Only

Retiree
+Spouse

Retiree
+Child(ren)

Retiree
+Family

Pre-Medicare Eligible

UMR EPO Medical Plan

☐
☐
☐
☐
☐

Medicare Eligible

RetireeFirst/Anthem Medical Plan

☐
☐

Dental Insurance

(check one box only)

☐ Waive All Dental

☐ No Change

☐ Not Enrolled

Retiree
Only

Spouse
Only

Retiree
+Spouse

Retiree
+Child(ren)

Retiree
+Family

Dental Low Option Plan

☐
☐
☐
☐
☐

Dental High Option Plan

☐
☐
☐
☐
☐

Vision Insurance

(check one box only)

☐ Waive All Vision

☐ No Change

☐ Not Enrolled

Retiree
Only

Spouse
Only

Retiree
+Spouse

Retiree
+Child(ren)

Retiree
+Family

Vision Plan

☐
☐
☐
☐
☐

Dependent Information: Please complete the following information for the plans selected above.

Name (Last, First M.I.)	Medical	Dental	Vision	SSN	Sex M/F	Birth Date mm/dd/yyyy
Spouse	☐	☐	☐	- -		/ /
Dependent Child	☐	☐	☐	- -		/ /
Dependent Child	☐	☐	☐	- -		/ /

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Medicare Eligible Medical Plan Information

The Pre-Medicare Eligible Medical Plan will terminate on the date the retiree or spouse is Medicare eligible. The retiree may elect to continue Medical Plan coverage for the retiree or spouse through the Medicare Eligible Medical Plan. Enrollees of the Medicare Eligible Medical Plan must be enrolled in and maintain enrollment in Medicare Part A and Part B. Enrollees of the Medicare Eligible Medical Plan cannot be enrolled in another Individual Medicare Advantage (MA), Medicare Advantage Prescription Drug Plan (MAPD) or Individual Part D Prescription Drug Plan (PDP) at the same time as the Medicare eligible group plan through El Paso County. Failure to enroll by/with the required effective date, any lapse in Medicare Part A and Part B coverage, or enrollment in another Medicare plan will forfeit/terminate your Medical Insurance.

By signing below, I understand and agree that:

I have reviewed the available benefit choices and elect the options checked on this El Paso County Retiree Benefit Election form. Changes cannot be made during the Plan Year unless I experience a qualifying life event. It is my responsibility to notify El Paso County Employee Benefits Division in writing, within 31 days of any changes in eligibility for myself or my covered dependents, such as Medicare entitlement (age or disability). If I do not elect to continue or choose to waive a benefit at the time of retirement or during retirement, the benefit is forfeited for me and my dependents.

If I am becoming Medicare eligible and electing the County's offered Medicare Eligible Medical Plan, it is my responsibility to complete the enrollment process directly with Medicare for both Part A and Part B, to ensure that I am enrolled as of the required effective date, and to maintain Medicare Part A and Part B coverage. I cannot be covered under the County's Medicare Eligible Medical Plan if I enroll in another Individual Medicare Advantage (MA), Medicare Advantage Prescription Drug Plan (MAPD), or Individual Part D Prescription Drug Plan (PDP). Failure to enroll by/with the required effective date for Medicare Part A and Part B, any lapse in Medicare Part A and Part B, or enrollment in another Medicare plan will forfeit/terminate my Medical Insurance.

The Plan is not responsible for informing me of all my rights, benefits, and services under a selected healthcare provider. If in the future I accept full-time employment with El Paso County or the Pikes Peak Library District, it may affect my benefits. I acknowledge that my signature authorizes the release of the purchased service time information to the El Paso County Employee Benefits Division. If my full-time hire date was on or after January 1, 2022, retiree health plan benefits based on years of service will not include purchased years. If electing health plan benefits, I authorize the El Paso County Retirement Plan to deduct the premium contributions from my monthly pension and I will pay any amounts not covered by my pension by the first of each month. I understand that premiums and subsidy schedules are reviewed annually and, if premium contributions change, deductions and/or payments will be adjusted accordingly. I understand that late or non-payment of premium contributions will result in termination of coverage retroactive to the last day coverage was paid in full; termination of coverage means that the benefit will be forfeited for me and my dependents.

Retiree Signature: _____ Date: ____/____/____

Employee Benefits Division Use Only

Retirement Office Information:

Retirement Date: _____

Service Time: _____ Purchased Time: _____ Total Creditable Time: _____

Employee Benefits
Division Approved: _____