2022 Pre-65 Retiree Healthcare Enrollment Form

Retiree Name (First, Middle Initial, Last):	**SSN**		**DOB**
Spouse Name (First, Middle Initial, Last):	**SSN**		**DOB**
Street Address:	**City:**	**State:**	**ZIP:**
Phone:	**Email:**		
Alternate Phone:	**Alternate Email:**		

COVERAGE OPTIONS

Medical Plan Election	Plan Type	Tier
☐ Enroll ☐ Waive*	☐ CHSP Low Deductible Plan ☐ CHSP High Deductible Plan	☐ Retiree or Spouse Only ☐ Retiree + Spouse ☐ Retiree or Spouse + Child(ren) ☐ Family
Dental Plan Election	**Play Type**	**Tier**
☐ Enroll ☐ Waive*	☐ PPO Dental Plan	☐ Retiree or Spouse Only ☐ Retiree + Spouse ☐ Retiree or Spouse + Child(ren) ☐ Family
UHC Vision Election	**Plan Type**	**Tier**
☐ Enroll ☐ Waive*	☐ Base Plan ☐ Premier Plan	☐ Retiree or Spouse Only ☐ Retiree + Spouse ☐ Retiree or Spouse + Child(ren) ☐ Family

*If this waive option is elected, by signing below, I am confirming to opt out/waive this coverage option. I understand that in doing so, this is an irrevocable election, and by electing to opt out/waive this coverage, this/these benefits will not be available to me in the future.

ELIGIBLE DEPENDENTS TO BE COVERED:

Dependent(s)	Birth Date
Spouse	
Dependent Child	
Dependent Child	

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Retiree/Spouse Signature **Date**