RETIREE - 2024 BENEFITS ENROLLMENT FORM

Human Resources – Benefits Office
2800 U.S. Hwy. 281 North
San Antonio, Texas 78212

❑ **Open Enrollment** ❑ **Initial Enrollment** ❑ **Benefit Change**

HR Use Only
Monthly Cost: _____
Lawson ID: _____
Contribution Rate: _____
Hire Date: _____
Retirement Date: _____

SECTION 1 – RETIREE INFORMATION *(Please complete all sections.)*

Effective Date:

Last Name (Print)	First Name (Print)	Middle Initial	Birth Date (MM/DD/YR)	Last 4 digits of SSN XXX-XX-_____

Address	Apt #	City	State	Zip

Email Address	Home Phone Number	Cell Phone Number

SECTION 2 – MEDICARE INFORMATION *(If you and/or your dependent(s) are eligible for Medicare, you are required to be enrolled in Medicare Part A and B in order to participate in the SAWS Medicare Advantage Plan.)*

Both Parts A & B of Medicare			**Reason for Eligibility**			
Retiree	❑ Yes	❑ No	❑ Entitled Age	❑ Disability	❑ End-Stage Renal Disease	❑ Disability & Current Renal Disease
Spouse	❑ Yes	❑ No	❑ Entitled Age	❑ Disability	❑ End-Stage Renal Disease	❑ Disability & Current Renal Disease
Child	❑ Yes	❑ No	❑ Entitled Age	❑ Disability	❑ End-Stage Renal Disease	❑ Disability & Current Renal Disease

If Yes, attach a copy of your Medicare Card, your letter from Social Security, or the Railroad Retirement Board.

SECTION 3 – DEPENDENT INFORMATION *(Complete for each dependent enrolling or dropping coverage. If dropping coverage, also complete Section 6.)*

❑ Add ❑ Drop	Spouse Name (First Name, Middle Initial, Last Name)	Social Security Number	Birth Date (MM/DD/YR)	Gender ❑ M ❑ F
❑ Add ❑ Drop	Child Name (First Name, Middle Initial, Last Name)	Social Security Number	Birth Date (MM/DD/YR)	Gender ❑ M ❑ F
❑ Add ❑ Drop	Child Name (First Name, Middle Initial, Last Name)	Social Security Number	Birth Date (MM/DD/YR)	Gender ❑ M ❑ F
❑ Add ❑ Drop	Child Name (First Name, Middle Initial, Last Name)	Social Security Number	Birth Date (MM/DD/YR)	Gender ❑ M ❑ F

SECTION 4 – COVERAGE SELECTION *(If declining coverage skip Section 4 and complete Section 5 and 6.)*

A. Coverage Level *(Select one option only)*

❑ Retiree Only ❑ Retiree + Spouse ❑ Retiree + Child(ren) ❑ Retiree + Family

B. Health Options (*If declining coverage go to Section 5*)

Under Age 65 (Non-Medicare)			**Over Age 65 or Disabled (With Medicare A & B)**	
Retiree	❑ PPO Economy	❑ EPO Plus	**Retiree**	❑ Medicare Advantage ESA PPO Plan
Spouse	❑ PPO Economy	❑ EPO Plus	**Spouse**	❑ Medicare Advantage ESA PPO Plan
Child(ren)	❑ PPO Economy	❑ EPO Plus	**Child(ren)**	❑ Medicare Advantage ESA PPO Plan

SECTION 5 – EMERGENCY CONTACT INFORMATION

Contact Name	Contact Relationship to You	Contact Phone Number

SECTION 6 – DECLINATION OF HEALTH COVERAGE *(Complete if you and/or your dependent(s) are declining coverage.)*

❑ This is to certify the available coverage has been explained to me. I have been given the opportunity to apply for the coverage offered to me and my eligible dependents. I have voluntarily elected to decline the coverage as indicated below and am exercising my opt-out option at this time.

Reason for Declining Coverage

Name of Retiree:	❑ Other Group Coverage	❑ Medicare	❑ Medicaid	❑ Other
Name of Spouse:	❑ Other Group Coverage	❑ Medicare	❑ Medicaid	❑ Other
Name of Child:	❑ Other Group Coverage	❑ Medicare	❑ Medicaid	❑ Other
Name of Child:	❑ Other Group Coverage	❑ Medicare	❑ Medicaid	❑ Other
If reason for declining is "Other", please explain:				

COVERAGE CONDITIONS

1. I am a retiree of the San Antonio Water System. I am eligible to participate in the health coverage(s) afforded by SAWS Health and Welfare Benefit Plan ("Plan"), which is either underwritten or administered by United Healthcare (UHC), OptumRx, and Aetna. On behalf of myself and any dependents listed on this enrollment application, I apply for those coverage(s) for which I am eligible. Furthermore, if this is an initial enrollment election, I waive the COBRA rights I have with respect to health coverage under the Plan, for myself and for any children I am electing to enroll. My spouse (if applicable) is also waiving on his/her own behalf. I state that the information on the application is true and correct. I understand and agree that any incorrect statements knowingly made by me will invalidate my coverage(s).
2. Only those coverage(s) and amounts for which I am eligible will be available to me. I understand that if this application is accepted, the Plan provisions regarding the coverage(s) will determine when the effective date.
3. I authorize SAWS to deduct from my SAWS Retirement Plan benefit check or, if I do not receive a SAWS Retirement Plan benefit check, to draft my bank account for my portion of the contributions, if any, as they become due or ensure timely payment on a monthly basis. I also agree that my participation in the Plan is subject to any future amendments.
4. I understand that if I do not pay required premiums when due, my coverage/s under the Plan will be terminated.
5. I understand that if I elect health coverage for my spouse, a spouse premium surcharge will be applied to my premium unless I submit a Spouse Premium Surcharge Waiver form to HR Benefits. SAWS will not retroactively reimburse amounts already paid due to failure to submit a timely waiver.
6. I authorize any hospital, physician, dentist, provider, insurance carrier, or other entity, upon request, to provide SAWS/United Healthcare/OptumRx/Aetna any information covering the health condition of any person included under my coverage(s) whenever the information is considered necessary by SAWS/United Healthcare/OptumRx/Aetna for proper disposition of this application or of a claim submitted for payment.
7. I understand that Retirees may opt out of the health coverage offered under the Plan. If I, and/or my dependent(s) terminate or reject such coverage, I may re-enroll in the Plan at a later date, if I provide proof of continuous group insurance coverage during the period I and/or my dependent(s) were not enrolled and request enrollment within 31 days of the loss of that coverage.
8. I understand that if I and/or my dependent(s) become eligible for Medicare, that we are ***required to enroll in both Parts A & B***. I will contact SAWS HR Benefits Office and provide a copy of the Medicare cards within 30 days of receipt. I also understand that if the Part B effective date for myself or dependent(s) is delayed at initial enrollment that I will be placed in the Pre-65 PPO Economy Plan, and I may be required to complete another Enrollment Form.

REQUIRED SIGNATURES

- I understand that my signature on this Benefits Enrollment Form means that I have read and understood the contents of this form, including the Coverage Conditions, and that the information provided by me is accurate and complete.
- **This Benefits Enrollment Form must be signed, dated and received prior to your effective date of coverage. Upon receipt, the plan will process the form according to Centers for Medicare & Medicaid Services (CMS) guidelines.**

SAWS Retiree *Handwritten* Signature	**Date**
Spouse (if applicable) *Handwritten* Signature	**Date**

If someone assisted you in completing this form, please have that person sign below.

Signature and Printed Name	**Relationship to Applicant**	**Date**