RETIREE's SURVIVING SPOUSE/DEPENDENT CHILD(REN)
2024 BENEFITS ENROLLMENT FORM

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

HR Use Only
Monthly Cost: _____
Lawson ID: _____
Yrs of Service: _____
Hire Date: _____
Retirement Date: _____

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

Effective Date:

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

SECTION 2 – DEPENDENT INFORMATION *(Complete for each dependent. If dropping coverage complete Section 5)*

❑ Add ❑ Drop	Spouse Name (First Name, Middle Initial, Last Name)	Birth Date (MM/DD/YR)	Gender ❑ Male ❑ Female	Social Security Number
Address	City	State	Zip	Medicare Eligible ❑ Yes ❑ No
Cell Phone	Home Phone	Email Address		
❑ Add ❑ Drop	Child Name (First Name, Middle Initial, Last Name)	Birth Date (MM/DD/YR)	Gender ❑ Male ❑ Female	Social Security Number
Address	City	State	Zip	Medicare Eligible ❑ Yes ❑ No
Cell Phone	Home Phone	Email Address		
❑ Add ❑ Drop	Child Name (First Name, Middle Initial, Last Name)	Birth Date (MM/DD/YR)	Gender ❑ Male ❑ Female	Social Security Number
Address	City	State	Zip	Medicare Eligible ❑ Yes ❑ No

SECTION 3 – 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
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
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 4 – COVERAGE SELECTION

A. Coverage Level (Select one option only)

❑ Spouse Only ❑ Child(ren) Only ❑ Spouse & Child(ren) ❑ I decline medical coverage

B. Health Options

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

SECTION 5 – EMERGENCY CONTACT INFORMATION

If we are unable to reach you at the address and/or phone number provided, who may we contact:

Contact Name	Contact Relationship to You	Contact Phone Number

SECTION 6 – DECLINATION OF HEALTH COVERAGE

_____***Initial*** 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

Name of Surviving Spouse:	❑ Other Group Coverage	❑ Medicare	❑ Medicaid	❑ Other
Name of Surviving Child:	❑ Other Group Coverage	❑ Medicare	❑ Medicaid	❑ Other
Name of Surviving Child:	❑ Other Group Coverage	❑ Medicare	❑ Medicaid	❑ Other

If reason for declining is "Other", please explain:

COVERAGE CONDITIONS

1. I am a surviving spouse of 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) and Optum RX or Aetna. On behalf of myself and any other 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. 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 a surviving spouse on the United Healthcare Plan, 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/Optum RX/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/Optum RX/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's Surviving Spouse/Child(ren) *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**