EMORY

Return to:
Benefits Department, Human Resources
1599 Clifton Road, First Floor
Atlanta, GA 30322

RETIREE ELECTION FORM

RETIREE INFORMATION

Name (Last, First, M.I.)	Social Security Number	PeopleSoft ID (HR Use Only)
Street Address	City/State/Zip	
Marital Status ☐ Single ☐ Married ☐ Widowed	Home Phone	E-Mail

HEALTH CARE BENEFIT PLAN

MEDICAL PLAN

☐ Aetna POS
☐ BCBS-GA PPO
☐ I ***decline*** health coverage.

COVERAGE

☐ Retiree Only Under 65
☐ Retiree Only Over 65
☐ Retiree & Spouse (Both Under 65)
☐ Retiree & Spouse (Both Over 65)
☐ Retiree & Spouse (1 Over 65, 1 Under 65)
☐ Retiree & Family (1 Over 65, 1 Under 65, with Dependents)
☐ Retiree & Family (Both Under 65, with Dependents)
☐ Retiree & Family (Both Over 65, with Dependents)

DENTAL COVERAGE

☐ Aetna Traditional (Retiree Only)
☐ Aetna Traditional (2 Person)
☐ Aetna Traditional (Family)
☐ I ***decline*** dental coverage.

PERSONAL INFORMATION

Last Name	First Name	MI	Date of Birth MM/DD/YY	Sex	Relationship	Social Security Number	Medical *(please mark box)*	Dental *(please mark box)*
Retiree			/ /	M F	Self	XXX-XX-XXXX	☐ Yes ☐ No	☐ Yes ☐ No
Spouse			/ /	M F			☐ Yes ☐ No	☐ Yes ☐ No
Child(ren) Check box if a student over age 19		☐	/ /	M F			☐ Yes ☐ No	☐ Yes ☐ No
		☐	/ /	M F			☐ Yes ☐ No	☐ Yes ☐ No
		☐	/ /	M F			☐ Yes ☐ No	☐ Yes ☐ No

SIGNATURE (PLEASE READ CAREFULLY AND SIGN BELOW)

My signature below acknowledges that I have read all information contained on both sides of this form.

Signature ____________________ **Date** __________ **Accepted By** ______________ **HR Data Entry Init.** ________ **Date** _____

NOTE:

- It is important to continue your Emory health coverage each year if you want to take advantage of this benefit under our plan rules. If you elect to end your coverage through Emory, you cannot reinstate your coverage at a later date. The only other time coverage would end is if you failed to remit payments on a timely basis and again reinstatement is not possible under the plan's rules.

- If I elect Emory Health coverage, I hereby authorize all hospitals, physicians, medical service providers, pharmacists, employers, and all other agencies or organizations (including insurers and pre-paid health plans) to permit my choice vendor or its representatives to see or obtain a copy of all medical, prescribed drugs, HIV, and mental health diagnoses, and employment and insurance coverage records which pertain to me or any member of my family. This information will be used in connection with claims for benefits and utilization review and will be kept strictly confidential. This authorization shall remain valid for the term of this coverage. I understand that if a member is injured through the act or omission of another, the insurance vendor will require reimbursement for the benefits provided in an amount not to exceed any damages collected (where permitted by law).