EMORY ☐ Check here if your address has changed

PRE-65 ENROLLMENT FORM

RETIREE INFORMATION

Name (Last, First, MI.)	Last Four Digits of Social Security Number (SSN#)	PeopleSoft ID (HR Use Only)
Street Address		City/State/Zip
Home Phone	Alternate Contact Number	E-mail

HEALTH BENEFITS

MEDICAL PLAN (Aetna POS Plan)

You are currently enrolled in medical plan coverage which will automatically rollover. Check the box below if you wish to cancel medical coverage.

☐ **I decline medical coverage**

DENTAL PLAN (Aetna PPO Plan)

☐ **I decline dental coverage**
☐ **I select PPO Plan coverage**

Dental Plan Coverage Level:

☐ Retiree Only
☐ Retiree & Spouse
☐ Family

VISION PLAN (EyeMed Vision Care Plan)

☐ **I decline vision coverage**
☐ **I select EyeMed Vision Care Plan coverage**

Vision Plan Coverage Level:

☐ Retiree Only
☐ Retiree/Spouse
☐ Retiree & Children
☐ Family

A one-time draft for the annual premium is required. McGriff ACH Form must be completed to make payment.

☐ Check if you already have an ACH set up.

PERSONAL INFORMATION

	Last Name First Name MI.	Date of Birth MM / DD / YY	Gender	Relationship	Medicare Eligible	Last 4 SSN#	Medical (please mark box)	Dental (please mark box)	Vision (please mark box)
Retiree:		/ /		self	☐ YES ☐ NO		☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
Spouse:		/ /			☐ YES ☐ NO		☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
Child(ren):		/ /			☐ YES ☐ NO		☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
		/ /			☐ YES ☐ NO		☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
		/ /			☐ YES ☐ NO		☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO

SIGNATURE (PLEASE READ CAREFULLY AND SIGN BELOW)

If I elect medical, dental, or vision coverage, I authorize all hospitals, health care providers, pharmacists, employers, insurers, and all other entities to release medical, prescribed drugs, alcohol, substance abuse, employment and coverage records which pertain to me or my covered dependents to the Emory Benefit Plan(s) or its representatives. This information will be used in connection with benefit coverage and will be kept strictly confidential. This authorization shall remain valid for the term of this coverage unless I revoke it in writing. I understand that if I or my covered dependent is injured through the act of omission of another, the Emory Benefit Plan(s) will require reimbursement for the benefits provided in an amount not to exceed any damages collected. Typed name will suffice for a signature.

Signature/ Typed Name: **Date:**

Mail your form to: McGriff - Emory, P.O. Box 896881, Charlotte, NC 28289-6881 OR email as an attachment to: Lauren.Rice@McGriff.com

2024