EMORY ☐ Check here if your address has changed

PRE-65 MEDICAL/DENTAL ELECTION 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

☐ I decline medical coverage

☐ I select POS Plan coverage

MEDICAL PLAN COVERAGE LEVEL

☐ Hired prior to January 1, 2003

☐ Hired on/after January 1, 2003

- ☐ Retiree/Spouse Only
- ☐ Retiree & Spouse
- ☐ Retiree & Children
- ☐ Family
- ☐ Child(ren) Only

DENTAL PLAN

Dental Plan Coverage Level:

- ☐ Retiree Only
- ☐ Retiree & Spouse
- ☐ Family

PERSONAL INFORMATION

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

SIGNATURE (PLEASE READ CAREFULLY AND SIGN BELOW)

If I elect medical 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 Date:	**(HR Use Only)** Accepted by: HR Data Entry Init.: Date:

Emory University retirees, send completed form to: Benefits Department, Human Resources, 1599 Clifton Road, First Floor, Atlanta, GA 30322; Fax: 404-727-7145; hrbenef@emory.edu
Emory Healthcare retirees, send to: Emory Healthcare Employee Resource Center, 550 Peachtree Street Atlanta, GA 30308; Fax: 404-686-4750; ehc.hr/benefits@emoryhealthcare.org