EMORY ☐ Check here if your address has changed

RETIREE DENTAL & VISION ENROLLMENT FORM

RETIREE INFORMATION

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

HEALTH BENEFITS

DENTAL PLAN (Aetna PPO Plan)

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

Dental Plan Coverage Level:

☐ Retiree Only
☐ Retiree & Spouse
☐ Family

VISION PLAN (EyeMed Vision Care Plan)

☐ **I decline vision coverage**
☐ **I select the 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	Last 4 SSN #	Dental *(please mark box)*	Vision *(please mark box)*
Retiree:						Self		☐ Yes ☐ No	☐ Yes ☐ No
Spouse:								☐ Yes ☐ No	☐ Yes ☐ No
Child(ren):								☐ Yes ☐ No	☐ Yes ☐ No
								☐ Yes ☐ No	☐ Yes ☐ No
								☐ Yes ☐ No	☐ Yes ☐ No

SIGNATURE (PLEASE READ CAREFULLY AND SIGN BELOW)

If I elect dental and/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