City of Corpus Christi

Health Insurance Enrollment/Change Form for Retirees/Survivors

RETIREE INFORMATION		
PLEASE PRINT		
Retiree's Last Name	First Name	Middle Initial
Social Security Number	Date Of Birth	Phone
Address	City/State/Zip	Effective Date

Medicare Information	Group Health Plan	Group Health Coverage
Check if Participant has Medicare	Please select one	☐ Retiree Only
		☐ Retiree + Spouse
Retiree: Spouse:	☐ None/Terminate Coverage	☐ Retiree + Children
☐ Part A ☐ Part A	☐ Citicare	☐ Retiree + Family
☐ Part B ☐ Part B	☐ Citicare Fire	☐ Retiree's Children Only
Eff:_____ Eff:_____	☐ Citicare Public Safety	☐ Retiree's Spouse Only
	☐ Medicare Advantage Plan	

DEPENDENT INFORMATION

Dependent Information Last, First MI	Date of Birth	SSN	Gender	Relation	Add/ Drop

ACKNOWLEDGEMENT

I understand that I will be billed monthly for the premium to keep coverage in force. Failure to make timely payment will result in termination of coverage.
I understand that if I elect to cancel coverage for me and/or my dependents, I may not elect to enroll in the City's retiree health care plan in the future.

_____ _____

Signature **Date**

Office Use Only:

PS Entry Date:_____ **PS Entry Initials:_____**