Health Plan for Retired Registered Nurses Enrollment Form

Last Name	First Name	(M.I.)

Street Address

City	State	Zip Code

Date of Birth	Date of Hire	Date of Retirement	Telephone #

Social Security #

If you are over age 65 include your Medicare Health Insurance Claim Number (HICN)

MEDICAL COVERAGE

☐ I decline retiree medical coverage and acknowledge that neither I nor any of my eligible dependents will be given another opportunity to elect medical coverage under the Montefiore Health Plan for Retired Registered Nurses.

☐ I elect the Montefiore Health Plan for Retired Registered Nurses.

CHECK THE MEDICAL COVERAGE TYPE DESIRED:

☐ Single (you alone)

☐ Family (you and your spouse and/or eligible dependent children)

Coverage For Your Family Members – If you are eligible and have elected family coverage under the Retiree Health Plan, list the name, Social Security Number, birth date and relationship of each eligible family member below. If a family member is over age 65 include their Medicare Health Insurance Claim Number (HICN)

Name (Last, First, M.I.)	**Social Security #** **Medicare Health Insurance Claim Number (HICN)**	**Birth Date** (Month/Day/Year)	**Relationship to Retiree**

YOUR SIGNATURE

I have received and will read Montefiore's Retired Registered Nurses Summary Plan Description and updated information concerning benefit changes contained in the annual enrollment materials. I agree to accept all the terms and conditions of the Plan. I authorize Montefiore to continue these elections in effect until I change them or become ineligible for coverage.

Signature _____ Date _____

Complete this form and send a copy to:

Montefiore Medical Center
HR-Benefits Office
555 South Broadway, Bldg A, Tarrytown, NY 10591
T 914.349.8531 F 914.349.8584
Email: montebenefits@montefiore.org

Montefiore