

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 Medical Center Health Plan for Retired Registered Nurses.

CHECK THE MEDICAL COVERAGE TYPE DESIRED:

- Single (you alone)
- Family (you and your spouse or qualified same sex domestic partner 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 #	Birth Date (Month/Day/Year)	Relationship to Retiree
	Medicare Health Insurance Claim Number (HICN)		

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
 111 East 210th Street Bronx, NY 10467-2490
 T 914.378.6531 F 914.378.6584
 Email: montebenefits@montefiore.org

