CITY OF DETROIT POST-2014 NON-SAFETY EMPLOYEE
RETIREE HEALTHCARE TRUST
P.O. BOX 1497
TROY, MICHIGAN 48099-1497
(248) 641-4989

Dental / Vision Enrollment Form - 2026

Retired on or after January 1, 2015

Part I. Retiree Information (*required information)

*Last Name	*First Name	*MI	*Sex	*Social Security Number

*Street Address	*State	*State	*ZIP Code

*Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed	*Date of Birth (MM/DD/YYYY)

*Phone Number	Email Address

*Medicare Number	Medicare Part A Effective Date	Medicare Part B Effective Date

*Date Retired (MM/DD/YYYY)

Part II. Coverage Selection: Place an "X" in the box to select your dental and/or vision plan.

Dental Plan Options	Vision Plan Options	
DENCAP Dental Plan	**Heritage Standard Vision Plan**	**Heritage National Vision Plan**
☐ **Single** *$23.65*	☐ **Single** *$6.80*	☐ **Single** *$6.95*
☐ **Member +1** *$40.40*	☐ **Member +1** *$6.80*	☐ **Member +1** *$13.88*
☐ **Family** *$60.35*	☐ **Family** *$6.80*	☐ **Family** *$13.88*

Part III. Dependent Information:

Relationship to Retiree	Dependent Coverage Selection Dental	Vision	Last Name, First Name	Date of Birth (MM/DD/YY)	Sex	Social Security Number	Medicare Number	Medicare Effective Date
	Dental	Vision						
Spouse	☐	☐						
Child	☐	☐						
Child	☐	☐						
Child	☐	☐						

OVER

☐ **I DECLINE ALL COVERAGES - Dental and Vision**

Provide the requested information for each dependent that is to be enrolled in the above selected dental and/or vision plans. Be sure to select the box under the column "Dependent Coverage Selection" to indicate which plan(s) the dependent is to be enrolled in. If enrolling a Spouse, you must provide a copy of your marriage certificate. (In some instances, we may require that you submit documentation to substantiate Medicare eligibility and/or legal relationship of the dependents to the retiree.)

Part IV. Authorization: I have elected to enroll myself and my listed dependents in the above dental and/or vision plans, and hereby authorize the General Retirement System of the City of Detroit Post-2014 Non-Safety Employee Retiree Healthcare Trust to:

☐ **deduct my premium for such plan(s) from my monthly retirement pension check.**

Effective Date of Coverage: _____

_____ _____

Retiree Signature ***Date***