



City of Detroit General Retiree Healthcare Trust

HRA Opt Out Form

Name of Retiree: _____

Retiree SSN: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone #: _____

I would like to irrevocably **OPT OUT** of the retiree HRA effective _____. I understand that by completing and returning this form, I will **NOT RECEIVE ANY HRA CONTRIBUTIONS** from the City of Detroit General Retiree Health Care Trust (the "RHC Trust") on or after the effective date indicated above. I understand that this **OPT OUT IS IRREVOCABLE AND CANNOT BE CHANGED** until the next open enrollment period.

Retiree Signature: _____ Date: _____

If you would like to opt out of the spouse HRA benefit program ONLY, please complete the bottom portion of this form.

Name of Spouse: _____

Spouse SSN: _____

Signature of Spouse: _____ Date: _____

Please return this form to: City of Detroit General Retiree Healthcare Trust
BeneSys HRA Claims Department
P.O. Box 4955
Troy, MI 48099-4955