City of Detroit General Retiree Healthcare Trust

2025

Health Care Enrollment Form

(This Form Must Be Returned to BeneSys at P.O. Box 4955, Troy, MI 48099-4955 by November 27, 2024)

ONLY COMPLETE THIS FORM IF YOU ARE MAKING CHANGES TO YOUR ENROLLMENT OR ADDING A DEPENDENT TO COVERAGE

Part I. Retiree Information (*required information)

*Last Name	*First Name	*M.I.	*Social Security Number
*Street Address	Apt No.	*City	*State / *ZIP Code
* CMS Required Gender ☐ Male ☐ Female ☐ Non-Binary ☐ I Choose Not to Answer			
*CMS Required Sexual Orientation ☐ Lesbian or Gay ☐ Straight, in that, not lesbian or gay ☐ Bisexual ☐ I Choose Not to Answer			
* Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed			*Date of Birth (MM/DD/YYYY)
*Phone Number and Area Code	Email Address		
*Medicare Number	* Medicare Part A Effective Date	* Medicare Part B Effective Date	* Date Retired (MM/DD/YYYY)

CMS Required Race	Member	Spouse	CMS Required Ethnicity	Member	Spouse
American Indian or Alaska Native	☐	☐	Another Hispanic, Latino/a or Spanish Origin	☐	☐
Asian Indian	☐	☐	Cuban	☐	☐
Black or African American	☐	☐	Mexican, Mexican American, Chicano/a	☐	☐
Chinese	☐	☐	Not of Hispanic, Latino/a or Spanish Origin	☐	☐
Filipino	☐	☐	Puerto Rican	☐	☐
Guamanian or Chamorro	☐	☐	I choose not to answer	☐	☐
Japanese	☐	☐			
Korean	☐	☐			
Native Hawaiian	☐	☐			
Other Asian	☐	☐			
Other Pacific Islander	☐	☐			
Samoan	☐	☐			
Vietnamese	☐	☐			
White	☐	☐			
I choose not to answer	☐	☐			

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

Medicare Advantage Plan Options (Available to Pre-2015 retirees who are Medicare-eligible and their Medicare-eligible dependents) SELECT ONLY ONE MEDICAL PLAN	**Dental Plan Options** (Available to all General City Retirees) SELECT ONLY ONE DENTAL PLAN	**Vision Plan Options** (Available to all General City Retirees) SELECT ONLY ONE VISION PLAN
☐ BCBSM Medicare Plus Blue Group PPO ☐ Humana Group Medicare Advantage PPO ☐ BCN Advantage HMO-POS ☐ HAP Senior Plus HMO ☐ Priority Health HMO **OR** ☐ Health Reimbursement Account**	☐ Blue Cross Dental Plan ☐ Delta Dental Low Plan ☐ Delta Dental High Plan ☐ DENCAP Dental Plan (DMO)	☐ Heritage Standard Vision Plan ☐ Heritage National Vision Plan ☐ Vision Service Plan (VSP)

** Please refer to page 7 of the enrollment book for important information as it relates to your HRA.

Part III. Dependent Information:

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

☐ **I DECLINE ALL COVERAGES - Medicare Advantage, Dental, Vision and HRA**

Provide the requested information for each dependent that is to be enrolled in the above selected medical, 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 the legal relationship of the dependent to the retiree.)

Part IV. Authorization: I have elected to enroll myself and my listed dependents in the above medical, dental and/or vision plans, and hereby authorize the General Retirement System of the City of Detroit (“GRSCD”) to deduct or recover the amount of any required monthly cost-sharing contribution or premium for such plan(s) from my monthly retirement pension check.

_____ _____

Retiree Signature ***Date***