



City of Detroit General Retiree Healthcare Trust

2026

Non-Medicare Eligible HRA / Dental / Vision Enrollment Form

Retired on or before December 31, 2014

This Form Must Be Returned to BeneSys:

email: enrollmentdocs@benesys.com; fax: (248) 813-9898; mail: P.O. Box 4955, Troy, MI 48099-4955
by November 24, 2025

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.	*Sex	*Social Security Number
*Street Address	Apt No.	*City	*State	*ZIP Code
*Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed			*Date of Birth (MM/DD/YYYY)	
*Phone Number and Area Code	Email Address			
*Medicare Number (if applicable)	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.

Health Reimbursement Account	
<input type="checkbox"/> Health Reimbursement Account** ** Please refer to page 7 of the enrollment book for important information as it relates to your HRA	
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
<input type="checkbox"/> Blue Cross Dental Plan <input type="checkbox"/> Delta Dental Low Plan <input type="checkbox"/> Delta Dental High Plan <input type="checkbox"/> DENCAP Dental Plan (DMO) *MI Only, \$10 Office Visit Co-Pay*	<input type="checkbox"/> Heritage Standard Vision Plan <input type="checkbox"/> Heritage National Vision Plan <input type="checkbox"/> Vision Service Plan (VSP)

P.O. Box 4955 • Troy, MI 48099-4955

Phone 248-641-4913 • Facsimile 248-813-9898 • Toll Free 844-563-8911

www.ourbenefitoffice.com/mydetroitretireebenefits

Part III. Dependent Information:

	Dental	Vision	Last Name:	First Name:	Date of Birth:
Spouse	<input type="checkbox"/>	<input type="checkbox"/>	Last Name:	First Name:	Date of Birth:
			Social Security Number:	Medicare Number: <i>(if applicable)</i>	Medicare Effective Date: <i>(if applicable)</i>
Child	<input type="checkbox"/>	<input type="checkbox"/>	Last Name:	First Name:	Date of Birth:
			Social Security Number:	Medicare Number: <i>(if applicable)</i>	Medicare Effective Date: <i>(if applicable)</i>
Child	<input type="checkbox"/>	<input type="checkbox"/>	Last Name:	First Name:	Date of Birth:
			Social Security Number:	Medicare Number: <i>(if applicable)</i>	Medicare Effective Date: <i>(if applicable)</i>
Child	<input type="checkbox"/>	<input type="checkbox"/>	Last Name:	First Name:	Date of Birth:
			Social Security Number:	Medicare Number: <i>(if applicable)</i>	Medicare Effective Date: <i>(if applicable)</i>

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 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 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