



City of Detroit General Retiree Healthcare Trust

2025

Dental / Vision 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.	*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 Effective Date (if applicable)			
*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 (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)	<input type="checkbox"/> Heritage Standard Vision Plan <input type="checkbox"/> Heritage National Vision Plan <input type="checkbox"/> Vision Service Plan (VSP)

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