



# City of Detroit General Retiree Healthcare Trust

## 2026

### Dental / Vision Enrollment Form

**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 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.

<b>Dental Plan Options</b> (Available to all General City Retirees) SELECT ONLY ONE DENTAL PLAN	<b>Vision Plan Options</b> (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) <small>*MI Only, \$10 Office Visit Co-Pay</small>	<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:
<b>Spouse</b>	<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>
<b>Child</b>	<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>
<b>Child</b>	<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>
<b>Child</b>	<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.

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**Retiree Signature**

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**Date**