

City of Detroit General Retiree Healthcare Trust

2027
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 27, 2026

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: ☐ 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)	

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

Health Reimbursement Account

☐ 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
☐ Blue Cross Dental Plan	☐ Heritage Standard Vision Plan
☐ Delta Dental Low Plan	☐ Heritage National Vision Plan
☐ Delta Dental High Plan	☐ Vision Service Plan (VSP)
☐ DENCAP Dental Plan (DMO) *MI Only, $10 Office Visit Co-Pay*	

Part III. Dependent Information:

	Dental	Vision			
Spouse	☐	☐	Last Name:	First Name:	Date of Birth:
			Social Security Number:	Medicare Number: *(if applicable)*	Medicare Effective Date: *(if applicable)*
Child	☐	☐	Last Name:	First Name:	Date of Birth:
			Social Security Number:	Medicare Number: *(if applicable)*	Medicare Effective Date: *(if applicable)*
Child	☐	☐	Last Name:	First Name:	Date of Birth:
			Social Security Number:	Medicare Number: *(if applicable)*	Medicare Effective Date: *(if applicable)*
Child	☐	☐	Last Name:	First Name:	Date of Birth:
			Social Security Number:	Medicare Number: *(if applicable)*	Medicare Effective Date: *(if applicable)*

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***