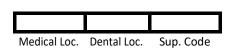
CITY OF CHARLESTON



(First)

(Middle)

Retiree BENEFIT PLAN ENROLLMENT CARD

(Last)

Effective Date of Coverage				
/	/			
Hire Date				
	/			

Department

Date

Social Security Number

-Retiree -Widow

Member Information

Name_

Address_

Member Signature

Street					City		State	Zip Code		
Date of Birth	:	J				Marital Status:	-Single	-Married	-Widowed	-Divorced
Telephone Number: Phone #						Alternate Phone #				
MEDICAL elect single Sex elect member + one child Male elect member + spouse Female elect family do no elect coverage				Ţ	DENTAL/VISION elect single Enhanced elect family do no elect coverage					
			Name	s of Dep	enden	ts To Be Cov	ered:			
Name		Social Security Number		Relationship	Sex M/F	Birthdate	Full Time Student Y/N	Handicapped Y/N		
	ı	ABOUT YOUR OTH	IER GROUP OF	R NON-GROUP	HEALTH INS	URANCE COVERAGE A	ND MEDICA	RE		
Do you or any	of your deper	ndents have othe	er health cov	erage?	Yes	No If "YE	S", comple	te the following	boxes	
Name(s) of Covered Persons Name of Other		Name of Other Ins	surance Co. Policy Number		mber	Effective Date/Cancel Date		Coverage Type(s)		
								O Medical O Dental	O Prescrip O Vision	tion Drug
		ck the appropri				or you and depende sease.	nts who ar	e covered by M	edicare.	
O-You Medicare# Eff. Date - Part A:			A:	Part B:				Renal Disease		
O-Spouse Medicare# Eff. Date - Part A:			A:	Part B:				Renal Disease		
O-Dependent Medicare# Eff. Date - Part A:			A:	Part B:				Renal Disease		
Do any of the 1. Depender	•	isted above live		t city? Y or N & State	I If Yes list	below the depende 2. Dependent	ent(s) and t	he city and state	e in which they l City & Stat	

(Please check other side)

Healthcare Premium Discount Enrollment Verification

Overview & Instructions: The City of Charleston offers a Non-Tobacco User (NTU) healthcare premium discount. If you enroll in the City's healthcare plan, **you must select one (1) box in below.** Please complete the form in its entirety.

Healthcare Premium Selection (Please Select only 1 Bo	<u>×</u>)
Standard Rate: Select this option if you and/	or applicable spouse are a Tobacco User.
being a non-tobacco user. To participate and	nis option if you would like to receive a reduced discounted rate for d be eligible to receive a reduced discounted healthcare premium, spouse, if applicable, do not use tobacco products.
Certification By signing below, I do hereby certify, acknowledge and and complete to the best of my knowledge.	agree the information provided herein is true, accurate
Member Signature	Date