CITY OF CHARLESTON

Retiree
BENEFIT PLAN ENROLLMENT CARD

Medical Loc. Dental Loc. Sup. Code

O -Retiree O -Widow

Effective Date of Coverage
_____/_____/_____

Hire Date
_____/_____/_____

Department

Member Information

Name_____
(First) (Middle) (Last)

Social Security Number

Address_____
Street City State Zip Code

Date of Birth: _____/_____/_____

Marital Status: O -Single O -Married O -Widowed O -Divorced

Telephone Number: Phone # _____

Alternate Phone #_____

Sex
O Male
O Female

MEDICAL
O elect single
O elect member + one child
O elect member + spouse
O elect family
O do no elect coverage

DENTAL/VISION
O elect single
O elect family
O do no elect coverage

DENTAL/VISION PLAN OPTION
O Standard
O Enhanced

Names of Dependents To Be Covered:

Name	Social Security Number			Relationship	Sex M/F	Birthdate	Full Time Student Y/N	Handicapped Y/N

ABOUT YOUR OTHER GROUP OR NON-GROUP HEALTH INSURANCE COVERAGE AND MEDICARE

Do you or any of your dependents have other health coverage? Yes No If "YES", complete the following boxes

Name(s) of Covered Persons	Name of Other Insurance Co.	Policy Number	Effective Date/Cancel Date	Coverage Type(s)
				O Medical O Prescription Drug
				O Dental O Vision

Medicare Information - Check the appropriate boxes and fill in all information for you and dependents who are covered by Medicare.
***Check box below for each individual receiving treatment for end-stage renal disease.**

O-You	Medicare#	Eff. Date - Part A:	Part B:		Renal Disease
O-Spouse	Medicare#	Eff. Date - Part A:	Part B:		Renal Disease
O-Dependent	Medicare#	Eff. Date - Part A:	Part B:		Renal Disease

Do any of the dependents listed above live in a different city? Y or N -- If Yes list below the dependent(s) and the city and state in which they live.
1. Dependent_____ City & State 2. Dependent_____ City & State

_____/_____
Member Signature Date

(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 Box)

☐ **Standard Rate**: Select this option if you and/or applicable spouse are a Tobacco User.

☐ **Non-Tobacco User (NTU) Discount:** Select this option if you would like to receive a reduced discounted rate for being a non-tobacco user. To participate and be eligible to receive a reduced discounted healthcare premium, you must certify that you and your covered spouse, if applicable, do not use tobacco products.

Certification

By signing below, I do hereby certify, acknowledge and agree the information provided herein is true, accurate and complete to the best of my knowledge.

Member Signature _____ Date _____

C-Lect - Flexible Spending Account (FSA)

Police and Fire Retirees

Annual Minimum $180.00 to Annual Maximum $3050.00
Monthly per pay deduction $15 to $254.16

Retiree Information

Employee's Name (Last, First, Middle)	Social Security Number		Date of Birth
Employee's Address	City	State	ZIP

Dependent Information

Spouse's Name	Date of Birth
Dependent Name	Date of Birth
Dependent Name	Date of Birth
Dependent Name	Date of Birth
Dependent Name	Date of Birth
Dependent Name	Date of Birth

I request that my pension be reduced $_____ per month, for an Annual Total:$

Authorization for Flexible Spending Account

Authorization: I certify the above information to be correct and true to the best of knowledge and that the children based under "Dependent Coverage" either reside with me in a parent-child relationship or are legally dependent on me for support. I understand that any amounts remaining in my account(s) not used for eligible expenses incurred during the plan year will be forfeited in accordance with current plan provisions and tax laws. I further understand that the Flexible Compensation reduction(s) will be in effect for the plan year and cannot be revoked unless I experience a change in my family status or termination of spouse's employment.

Signature_____ Date_____

REMINDER: This enrollment is for the plan year of July 1, 2023 to June 30, 2024.