2025 ENROLLMENT/CHANGE FORM

Retiree Information

Name _____ SSN _____

Address_____ Home Phone Number _____

City, State, Zip Code_____

Email Address_____

Section 1:

Medical	☐ **Maintain** Medical Coverage	☐ **Remove** Medical Coverage (See Section 2)
		☐ **Change to** POS Medical coverage
Dental	☐ **Maintain** Base Dental coverage	☐ **Remove** Dental Coverage (See Section 2)
		☐ **Change to** Base Dental Plan
	☐ **Maintain** Buy-Up Dental coverage	☐ **Change to** Buy-Up Dental Plan
Vision	☐ **Maintain** Base Vision coverage	☐ **Remove** Vision Coverage (See Section 2)
		☐ **Change to** Base Vision Plan
	☐ **Maintain** Buy-Up Vision coverage	☐ **Change to** Buy-Up Vision Plan

Section 2: Dependent Information: If you are dropping coverage on any eligible dependent, please complete the following information. You are unable to add dependents to coverage after your retirement.

	Name (Last, First, MI)	DOB	SSN	REMOVING COVERAGE ON:
Retiree				☐Medical ☐Dental ☐Vision
Spouse				☐Medical ☐Dental ☐Vision
Child 1				☐Medical ☐Dental ☐Vision
Child 2				☐Medical ☐Dental ☐Vision
Child 3				☐Medical ☐Dental ☐Vision

Beneficiary Designation Basic Life Insurance

City of Marietta provides each retiree with a Basic Life Insurance Policy. Please indicate your beneficiary below.

Name (First and Last)_____ _____ Relationship _____Percent of Benefits*_____

Address _____ Phone Number _____

Name (First and Last)_____ _____ Relationship _____Percent of Benefits*_____

Address _____ Phone Number _____

***Percentages must equal 100%. Proceeds will be paid to those beneficiaries who survive you. If a beneficiary predeceases you, then that beneficiary's share will be distributed equally among the other surviving beneficiaries. If beneficiary is not related to you, please provide Date of Birth, Social Security number, and full address on separate paper.**

Retiree Signature	Please return this form to NFP or HR Benefits.

Print Name/Signature: _____ Date: _____