

Annual Retiree Open Enrollment/Plan Change Form

PERSONAL INFORMATION

Member ID: *(if applicable)* _____ SSN: _____

Member Name: Last: _____ First: _____ Initial: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: (____) _____ - _____ Cell: (____) _____ - _____ Email: _____

Gender: M [] F [] Date of Birth ____/____/____ Title: Rev. [] Dr. []

Relationship Status: Single [] Married [] Date of Marriage: ____/____/____ Divorced [] Widowed []

Spouse Name: _____ Spouse Date of Birth: ____/____/____

Spouse SSN: _____

OPTIONAL BENEFIT PLANS

Information about our optional benefit plans is available online. Visit our website at www.pbucc.org and select the Pension & Benefits option to review plan materials.

I elect the following Plan changes:

(Include a copy of your Medicare card if enrolling in the UCC Medicare Advantage Plan.)

- | | | |
|--|---------------------------------|---------------------------------|
| ☐ UCC Medicare Advantage Plan | ☐ Enroll | ☐ Cancel |
| ☐ UCC Dental Benefits Plan | ☐ Enroll | ☐ Cancel |
| ☐ UCC Vision Benefits Plan | ☐ Enroll | ☐ Cancel |

DEPENDENT INFORMATION FOR INSURANCE

You must complete this section if you are applying for spouse/partner health benefits.

[] I have included a copy of my spouse's/partner's Medicare ID card (if applying for the Medicare Advantage Plan only)

Name of Spouse/Partner	Date of Birth	Gender	SSN	Plan Elected	Plan Cancelled
				☐ Medicare Advantage ☐ Dental ☐ Vision	☐ Medicare Advantage ☐ Dental ☐ Vision
My spouse/partner is also a UCC member: YES NO			Spouse Member ID <i>(if known)</i>		

RETIREE (Member) AGREEMENT

By signing this form, I hereby enroll in the benefits above. If my status or my dependent's status changes, I agree to notify the Pension Boards immediately.

Self-Pay Members: Billing Preference (Please choose one):

- ☐ I agree to have my monthly premiums deducted from my monthly annuity payment. Your monthly annuity benefit must be large enough to accommodate this deduction. If not, you will receive a monthly bill instead. *Minimum threshold to pay out is at least \$50 monthly in annuities.*
- ☐ I agree to accept a monthly e-bill notice which will instruct me to login and pay online via www.pbucc.org.

Retiree (Member) Signature: _____ Date: ____ / ____ / ____

Please return this signed and completed form:

By email to: info@pbucc.org

By fax: 212.729.2701

Or mail to: Pension Boards-UCC, 475 Riverside Drive, Suite 1020, New York, NY 10115