University Health

2025 Retiree Benefits Election Form

Last Name	First Name	M.I.	Social Security Number		Date of Birth
Street Address	**City**		**State**	**Zip code**	**Phone Number:**

Medical Enrollment:
(If you are enrolled in Medicare Part A and/or Part B, you may be eligible for a premium discount to your medical benefit. To qualify for this discount, please submit a copy of your Medicare ID card to our retirement team at retirement@uhtx.com)

❑ **University Family Care Plan**	**Medical (without Medicare primary)** ❑ Retiree Only ❑ Retiree and Spouse	**Medical (with Medicare primary)** ❑ Retiree Only ❑ Retiree and Spouse	❑ Decline

Dental Enrollment: (Choose One from the 4 Plans Listed)

Humana DHMO ❑ DHMO	**Humana DPO** ❑ Bronze Plan ❑ Silver Plan ❑ Gold Plan	**Coverage Level** ❑ Retiree Only ❑ Retiree and Spouse	❑ Decline

Vision Enrollment:

❑ **EyeMed**	❑ Retiree Only	❑ Retiree and Spouse	❑ Decline

Please complete the information below for yourself and dependents that are covered under your plan. If you are wanting to change your medical Primary Care Physician, you must contact CFHP at (210) 358-6090.

Name	Relationship	DOB	Gender (M/F)	Humana HS405 DHMO Provider:	Social Security Number	Medical (Y/N)	Dental (Y/N)	Vision (Y/N)
	Retiree							
	Spouse							

I certify that I am, and my enrolled dependent is, eligible to participate in plans elected for us on this form, as eligibility is defined in each plan.
I understand that my benefit elections cannot be changed or revoked before the next Open Enrollment unless there is an appropriate qualifying event (such as change in legal marital status, dependent eligibility, change of residence or Medicare/Medicaid eligibility). Changes must be requested and documented within 31 days of the event. I also understand that if I decline enrollment for myself in either the Medical, Dental or Vision plan at any time I will not be allowed to re-enroll at a later date for any reason. AUTHORIZATION: I hereby authorize my licensed physician, hospital, pharmacy, clinic, health care facility, insurance company, employer or organization to release to University Health or its agents any information regarding me or my enrolled family members' medical history, treatment, and/or disability that is reasonably necessary for the purpose of utilization review, coordination of benefits, or payment of a claim. The authorization shall cease to be effective at such time when my coverage under the plan terminates. In the event that I have any outstanding claims at time of termination, the authorization will continue to apply until all the claims have been settled. I hereby attest that the statements made by me are true, and I understand that any material misstatements may be used to contest the validity of my benefits.

Retiree Signature:	Date:

Office Use Only	Effective Date:	Date Entered:	By:

White – Human Resources Yellow – Participant