## Health Insurance Enrollment Form For Retirees

This form is for retirees only who would like to make changes to their health insurance benefits for the following reasons:

- Annual Open Enrollment
- Qualifying Events – Marriage, Divorce, Death, Birth and loss of coverage
- Year-Round Changes to Beneficiaries -If you are making changes to your beneficiaries, the form must be notarized.
- To add or remove dependents
- An active employee transitioning to retiree status

Please provide a copy of your identification card and social security card if you are a new retiree. If you are adding dependents please provide a birth certificate and social security card for each dependent. If you are adding a spouse, please provide a marriage certificate and social security card for your spouse.

Once you have completed the form, please print and manually sign. Electronic signatures and submission of form via e-mail will not be accepted as we require original copies only.

Form must be mailed to the following address:

Division of Personnel
Group Health Insurance Unit
3438 Kronprindsens Gade, GERS Building 3rd Floor, St. Thomas, VI 00802
or
3009 Orange Grove Shopping Center, Suite 6-8, Christiansted, St. Croix, V.I. 00820

Should you have any questions, or need any additional information, please contact the Group Health Insurance office at 340-774-8588 or 340-718-8588.

**Please note, this form is for retirees only and not to be used by active employees.**

Authorization to Disclose Confidential Information

“I understand that the entity or entities providing benefits under the health insurance plan or plans procured by the Government of the Virgin Islands (the “Government”) and under which I am enrolled as a Government retiree, may require information concerning my health and the health of any covered dependent for the proper administration of the subject health insurance plan or plans. I hereby authorize any person or entity having any confidential information concerning my health or the health of my covered dependent to forward such information to any corporation or entity providing a health insurance plan or plans procured by the Government for its employees and retirees and in which I am enrolled. In addition, I authorize any corporation or entity providing a health insurance plan or plans procured by the Government for its employees and retirees and in which I am enrolled to release my confidential information, with respect to me and my covered dependents, to any person, company or entity when it determines that such disclosure information is necessary or appropriate for the administration of the subject health insurance plan or plans. “Confidential information” means, with respect to me and my covered dependents, any medical, dental, mental health, substance abuse, communicable disease, AIDS, and HIV related information and disability or employment-related information. The term “health insurance plan” includes the benefits set out in 3 V.I.C. § 632 (a) and any employee assistance program administered by the Government.”

# Health and Life Insurance Benefits Enrollment and/or Change Form

For use by Employees and Retirees

☐ GOVERNMENT OF THE VIRGIN ISLANDS
☐ UNIVERSITY OF THE VIRGIN ISLANDS
☐ VIRGIN ISLANDS PORT AUTHORITY

*Indicate Participant Type*: ☐ Employee ☐ Retiree

*Indicate Desired Enrollment Action*: ☐ New/Reinstate ☐ Change ☐ Annual/Open ☐ Cancel → Specify Type of Change / Cancellation and/or Qualifying Event, if applicable

## PARTICPANT'S INFORMATION (PLEASE PRINT)

Participant's Name (First, M.I., Last) | Social Security Number | Gender: ☐ Male ☐ Female | Marital Status: ☐ Single ☐ Married | Department | Employee Number

Mailing Address | City | State | Zip Code | Date of Birth (mm/dd/yyyy) | Date Hired/Retired (mm/dd/yyyy)

Do you or your dependents have other group medical insurance, including Medicare? ☐ Yes ☐ No | Work Phone x Ext. | Home Phone

Name of person who holds other insurance policy | Relationship of policyholder to you

Name of Insurance Company | Name of Employer or Government Department

## MEDICAL & DENTAL SELECTION

*I am hereby electing to: (Choose one)*

☐ Waive Medical & Dental Coverage
*(Proof of medical coverage via another source is required, to waive coverage.)*

☐ Enroll for Single Medical & Dental Coverage
☐ Enroll for Family Medical Only Coverage
☐ Enroll for Family Medical & Dental Coverage

*(Participant must be enrolled to enroll dependents. Proof of dependency, such as marriage and/or birth certificates, is required to enroll dependents for coverage.)*

## Vision

☐ Single
☐ Family
☐ Waive

## DEPENDENT LIFE SELECTION

☐ Waive Dependent Life
Elect Dependent Life for:
☐ Spouse ($10,000)
☐ Child(ren) ($5,000 each)

## COVERED DEPENDENTS' INFORMATION

| Dependent Names (First, M.I., Last) | Relationship | Gender M | Gender F | * Dependent Child up to 26 Y | * Dependent Child up to 26 N | Social Security Number | Date of Birth (mm/dd/yyyy) |
|---|---|---|---|---|---|---|---|
| | | ☐ | ☐ | ☐ | ☐ | – – | / / |
| | | ☐ | ☐ | ☐ | ☐ | – – | / / |
| | | ☐ | ☐ | ☐ | ☐ | – – | / / |
| | | ☐ | ☐ | ☐ | ☐ | – – | / / |
| | | ☐ | ☐ | ☐ | ☐ | – – | / / |
| | | ☐ | ☐ | ☐ | ☐ | – – | / / |
| | | ☐ | ☐ | ☐ | ☐ | – – | / / |

## BASIC / SUPPLEMENTAL LIFE & ACCIDENTAL DEATH & DISMEMBERMENT (AD&D) INSURANCE

*For employees, The Government & University provide a $10,000 Life/AD&D benefit: Port Authority provides 1.5x basic annual salary.*
*Employees may elect to purchase Supplemental Life/AD&D Insurance based on ONE (1) of the following Plans:*

**Plan A**: ☐ 1x Basic Annual Salary ☐ 2x Basic Annual Salary ☐ 3x Basic Annual Salary ☐ 4x Basic Annual Salary
*(Round salary to the next higher $1,000 for benefit amount)*

**Plan B**: ☐ $10,000 ☐ $15,000 ☐ $25,000 ☐ $50,000 ☐ $75,000 ☐ $100,000 ☐ $150,000

Salary Amount | Benefit Amount | ☐ Waive Supplemental Life/AD&D

*Underwriting* ☐ Approved ☐ Disapproved Date: | *up to $500,000* | *(Evidence of Insurability is required to increase current benefit by more than $5,000)*

*For retirees, The Government provides a $5,000 Basic Life benefit.*
*Retirees may elect to purchase Supplemental Life based on ONE (1) the following:*

☐ $10,000 ☐ $15,000 ☐ $20,000 ☐ $25,000
☐ $30,000 ☐ $50,000 ☐ $75,000 ☐ $100,000
☐ $150,000 ☐ Maintained $5,000 ☐ Waive Supplemental Life

*Underwriting* ☐ Approved ☐ Disapproved Date:

## BENEFICIARY DESIGNATION

| Beneficiary Name (First, M.I., Last) | Date of Birth | Relationship | Social Security Number | % Share |
|---|---|---|---|---|
| | / / | | – – | % |
| | / / | | – – | % |
| | / / | | – – | % |
| | / / | | – – | % |
| | / / | | – – | % |

## FOR HEALTH INSURANCE OFFICE USE ONLY

*Health* $ _____ *Supplemental Life* $ _____ *Spouse Life* $ _____ *Child Life* $ _____

*Vision* $ _____ Bi-weekly payroll deductions in the total amount of $ _____ will be withheld for coverage

Effective / / (mm/dd/yyyy) | Processed by | / / Date Processed

## PARTICIPANT'S AUTHORIZATION

By signing below I accept the conditions set forth on the reverse side of this form. I certify that the information indicated above is true and correct to the best of my knowledge, and authorize bi-weekly payroll deductions for these selections and/or changes.

Participant's Signature | / / Date (mm/dd/yyyy)

**Attention: Required Documentation**
**Please submit a copy of your and/or your eligible dependent's Medicare card Part A & B. Please note, your health insurance coverage will be cancelled if the required document is not submitted.**