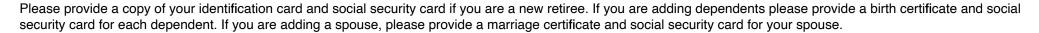
Health Insurance Enrollment Form For Retirees

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



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."



GOVERNMENT OF THE VIRGIN ISLANDS Indicate Particip UNIVERSITY OF THE VIRGIN ISLANDS VIRGIN ISLANDS PORT AUTHORITY Participant's Name (First, M.I., Last) Mailing Address	loyee	H H	Change → Specificancel and/or E PRINT) Gender Male Female	Qualifying Event, Marital Status Single Married Zip Code		Employee Number 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	Relati	ionship of policyholder to y	ou		() x	()
Name of Insurance Company Name of Employer or Government Department						
MEDICAL & DENTAL SELECTION VISION DEPENDENT LIFE SELECTION						
I am hereby electing to: (Choose one)		(Participant must be dependents. Proof of comarriage and/or birth centerful dependents for covered to the content of the conte	dependency, such as dificates, is required to	Single Family Waive	Waive Dependent Lift Elect Dependent I Spouse (\$10,000) Child(ren) (\$5,000 ea	Life for:
COVERED DEPENDENTS' INFORMATION						
	onship Gende		ndent Child up to 26		isial 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. For retirees, The Government provides a \$5,000 Basic Life benefit.						
Employees may elect to purchase Supplemental Life/AD&D Insurance based on ONE (1) of the Plan A	Plan B \$10,000 \$75,000 Supplemental Life/AD&D (Evidence of Insurability is required)	\$15,000 \$25,000 \$150,000 \$100,000 \$150,000	\$50,000 Retires		thase Supplemental Life based on ON \$15,000 \$20,000 \$75,000 \$75,000 Approved Disappro	\$25,000 \$100,000 Welve Supplemental Life
Beneficiary Name (First, M.I., Last)		EFICIARY DESIGNATION	Deletionship		Pacial County Number	% Share
Generically Name (First, M.I., Last)	Date of Birth	/ / / /	Relationship		Social Security Number	% Snare % % % % %
FOR HEALTH INSURANCE OFFICE USE ONLY PARTICIPANT'S AUTHORIZATION						
Health \$ Supplemental Life \$ Spouse Life \$ Vision \$ Bi-weekly payroll deductions in the total amount of \$ Effective / /	will be withheld for covers	correct to the best	of my knowledge, and au		side of this form. I certify that the inform yroll deductions for these selections and	

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.