Employee Benefits
4 Irving Place - 15th Floor S
New York, NY 10003

conEdison

Retiree Health & Dental Program
Change Request Form

Please print or type. Check appropriate boxes.

A. RETIREE OR SURVIVING SPOUSE INFORMATION

☐ Management ☐ Weekly

Name: Last_____ First_____ M.I.____ Employee Number_____

Home Telephone ____-____-____ Cell Phone ____-____-____ Date of Birth_____
mm/dd/ccyy

Email Address _____

Alternate Contact Name _____ Alternate Contact Telephone____-____-____

MEDICARE: *If eligible, copy the following information from your Medicare Health Insurance Card:*

Medicare Claim Number____-____-____ ☐ Over 65 ☐ Disabled and under 65

B. ENROLLMENT

*Directions: To **disenroll** from health and/or dental coverage,complete section 1; to **change** health and/or dental enrollment, complete section 2; complete section 3 and list any covered/disenrolled dependents.*

1. DISENROLL FROM HEALTH AND/OR DENTAL COVERAGE: As of **Month** _____ **Year**_____

I elect to disenroll from the following health and/or dental coverage(s):

☐ **Cigna Medical** ☐ **Caremark Prescription Drug** ☐ **HMO Option** *List HMO name:*_____

☐ **MetLife Basic Dental Plan** ☐ **MetLife Premium Dental Plan**

2. CHANGE REQUEST FOR HEALTH AND/OR DENTAL COVERAGE: As of **Month** _____ **Year** _____

I elect to change my health and/or dental coverage enrollment to:

☐ **Cigna Medical** ☐ **Caremark Prescription Drug** ☐ **HMO Option** *List HMO name:*_____

☐ **MetLife Basic Dental Plan** ☐ **MetLife Premium Dental Plan**

3. I wish to enroll/disenroll myself and/or my dependents as follows (please complete health and dental below).
Note: your covered spouse/dependents must elect the same health and dental plan as you if they enroll.

	Cigna Medical	Caremark Prescription Drugs	HMO	Retired Officers' Plan	Elect not to enroll health	MetLife Basic Dental Plan	MetLife Premium Dental Plan	Elect not to enroll dental
Retiree (self)	☐	☐	☐	☐	☐	☐	☐	☐
My spouse	☐	☐	☐	☐	☐	☐	☐	☐
My dependent child(ren)	☐	☐	☐	☐	☐	☐	☐	☐

SPOUSE AND DEPENDENT CHILDREN INFORMATION: *If you have more dependents, please attach an additional sheet.*

Relationship	First Name	MI	Last Name	Gender (M / F)	DOB mm/dd/ccyy	Social Security #	Handi-capped (Y / N)	If Medicare eligible, copy the following from the dependents Medicare Health Insurance Card:		Full-Time Student (Y / N)
								Medicare Claim #	Over 65 / Disabled & under 65	
☐ Spouse ☐ Child									☐ Disabled and under 65 ☐ Over 65	
☐ Spouse ☐ Child									☐ Disabled and under 65 ☐ Over 65	

C. AUTHORIZATION - **I understand** and **confirm** the following:

- I must enroll in the medical/prescription/dental plans within 31 days of becoming eligible for coverage. I may not be able to enroll in the future unless I provide proof of continuous coverage with another group health plan.
- I may only change my coverage during open enrollment or if I have a qualifying life event.
- If Medicare Eligible I **Must Enroll** in Medicare Part A & B in order to continue participation.
- If I elect dental coverage, I cannot change my plan choice for two consecutive years of enrollment.
- I authorize Consolidated Edison Company of New York, Inc. to deduct from my retirement benefit each month the applicable contribution toward the cost of health and/or dental coverage for the person(s) indicated above.
- I understand that Con Edison reserves the right to change or terminate retiree health and/or dental benefits at any time.
- My election shown above and this authorization shall continue in force unless I change it by completing an Enrollment/ Change Form and filing it with Employee Benefits at the address listed above.

Retiree Signature _____ **Date**_____