

## Retiree Health Benefit Enrollment Change Form Instructions

**SECTION 1 – EMPLOYEE INFORMATION** – Complete entire section

**SECTION 2 – COMPANY**– Check one only

**SECTION 3 – MEDICARE STATUS** – Check one only. Provide MBI # if eligible

**SECTION 4 – ACTION REQUESTED** – Check one only

**SECTION 5– QUALIFYING LIFE EVENT (QLE)** – Check one only

- **Marriage** – attach copy of supporting document(s) such as a marriage certificate
- **Divorce** – attach copy of supporting document(s) such as legal separation papers, divorce decree
- **Birth/Adoption** – attach copy of supporting document(s) such as a birth certificate, live birth letter from hospital or pediatric doctor on doctor’s letter head specifying names of parents, adoption decree
- **Death** - attach copy of supporting document(s) such as death certificate
- **Loss of Coverage** – request enrollment because of loss of other coverage. Attach proof of loss of coverage detailing type of plan such as medical, dental, prescription, vision
- **Gain of Coverage** – request to disenroll because gain of other coverage. Attach proof of gain in coverage detailing type of plan such as medical, dental, prescription, vision
- **Date of Life Event** – List the date.

The effective date for change in benefits when reporting a life event will depend on the date of submission:

- Within 30 days ----- Effective the date of the life event
- After 30 days ----- Must wait to enroll during the next annual Open Enrollment

**SECTION 6– TYPE AND LEVEL OF COVERAGE** – check box to enroll in Health and/or Dental

- **Retiree** – coverage for you only
- **Retiree + 1** – coverage for you and your eligible dependent
- **Family** – coverage for you and two or more of your eligible dependents
- **Surviving Spouse** - coverage for you, or you and your eligible dependents

**SECTION 7 – HEALTH PLAN** – Select only one plan from your retirement group. A Summary of Benefits can be found on the Retiree Website at [Health Benefits](#).

- If Medicare Eligible you must enroll in Medicare Part A & B.
- If you elect dental coverage, you cannot change your plan choice for two consecutive years of enrollment.

**SECTION 8– SPOUSE/DEPENDENT INFORMATION** – List all eligible dependents and attach proof of dependent documentation. If proper documentation has already been provided and approved, do not resubmit. If proper proof of dependent documentation is not provided, dependents may not be enrolled. Ensure your dependents match your level of coverage (Section 6). Dependent children are covered until age 19. Dependent children between ages 19 to 23 must provide proof of full-time student status. If you have a disabled child over 19 years of age, please apply for a disability certification from your health provider to maintain eligibility of coverage.

**SECTION 9 – RETIREE SIGNATURE** – Read, sign, date, and attach required dependent documentation.

- You 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.
- You understand that Con Edison reserves the right to change or terminate retiree health and/or dental benefits at any time.
- Your election and this authorization shall continue in force unless you change it by completing an Enrollment/Change Form and filing it with Employee Benefits at [benefits@coned.com](mailto:benefits@coned.com).

**SUBMIT** the enrollment form with attachments to [benefits@coned.com](mailto:benefits@coned.com). You will receive a reply with a case number to your personal email address.

**MISREPRESENTATION:** Any person that knowingly provides false or misleading information is subject to criminal and civil penalties.

## Retiree Health Benefit Enrollment Change Form

<b>1. EMPLOYEE INFORMATION</b> – (Last, First, M.I.)							<b>EMPLOYEE NO.</b>			
<b>Telephone Number</b> (    )    -				<b>Personal Email Address</b>						
<b>2. COMPANY</b> <input type="checkbox"/> CECONY <input type="checkbox"/> O&R <input type="checkbox"/> Officer										
<b>3. MEDICARE STATUS</b> <input type="checkbox"/> Disable and Under 65 <input type="checkbox"/> Over 65    Medicare Beneficiary Identifier (MBI) # _____ <input type="checkbox"/> Not Medicare Eligible										
<b>4. ACTION REQUESTED:</b> <input type="checkbox"/> New Retirement/Dependent <input type="checkbox"/> Surviving Spouse <input type="checkbox"/> Add Self/Dependent <input type="checkbox"/> Drop Self/Dependent										
<b>5. QUALIFYING LIFE EVENT (Check one)</b> <input type="checkbox"/> Marriage <input type="checkbox"/> Divorce <input type="checkbox"/> Birth/Adoption <input type="checkbox"/> Death <input type="checkbox"/> Loss Coverage <input type="checkbox"/> Gain Coverage  Date of Event ____/____/____					<b>6. TYPE and LEVEL OF COVERAGE</b> <input type="checkbox"/> Employee <input type="checkbox"/> Employee + 1 <input type="checkbox"/> Family <input type="checkbox"/> Surviving Spouse					
<b>7. HEALTH PLANS</b>										
<b>Consolidated Edison</b>					<b>Orange &amp; Rockland</b>					
<b>Medical/Prescription Drug/Vision</b> <input type="checkbox"/> Cigna /CPS Vision <input type="checkbox"/> CVS Health <input type="checkbox"/> HMO/Managed Choice List: _____					<b>Medical/Prescription Drug /vision</b> <input type="checkbox"/> Cigna /CVS Health/CPS Optical					
<b>Dental</b> <input type="checkbox"/> MetLife Basic Plan <input type="checkbox"/> MetLife Premium Plan					<b>Dental</b> <input type="checkbox"/> MetLife Basic Plan <input type="checkbox"/> MetLife Premium Plan (Management Only)					
<b>8. SPOUSE/DEPENDENT INFORMATION:</b> List eligible dependents and attach required proof of dependency documents										
Relationship	First Name	MI	Last Name	Gender (M/F)	DOB MM/DD/CC YY	Social Security #	Disabl e (Y/N)	If Medicare eligible, copy the following from the dependents Medicare Health Insurance Card:		Full-Time Student (Y/N)
								Medicare Beneficiary Identifier (MBI) #	Under 65/Over 65	
<input type="checkbox"/> Spouse <input type="checkbox"/> Child									<input type="checkbox"/> Under 65 <input type="checkbox"/> Over 65	
<input type="checkbox"/> Spouse <input type="checkbox"/> Child									<input type="checkbox"/> Under 65 <input type="checkbox"/> Over 65	
<input type="checkbox"/> Spouse <input type="checkbox"/> Child									<input type="checkbox"/> Under 65 <input type="checkbox"/> Over 65	
<b>9. RETIREE SIGNATURE/AUTHORIZATION</b>										
I hereby authorize the Consolidated Edison Company of New York Inc. to make the appropriate changes relating to my health plan coverage, as I have indicated above, and to deduct from my paycheck, as applicable, my contribution toward the cost of the health plans. These elections and authorizations shall continue until changed in writing at my request										
Retiree Signature _____							Date ____/____/____			