

| ❖ <u>RETIREE INFORMATION</u> | | Return all completed forms to: | | | | |
|--|--|---|--|--|--|--|
| Name: R | etiree ID: | STATE OF VERMONT RETIREMENT DIVISION | | | | |
| Date of Birth: S | SN: | 109 STATE STREET | | | | |
| Home Phone: V | Vork Phone: | MONTPELIER, VT 05609-6901 | | | | |
| Street Address: City, State, Zip: | | | | | | |
| ❖ ACTION REQUEST | | | | | | |
| ☐ New Retiree ☐ Open Enrollm | ent Remove/Add De | pendent | | | | |
| If Add/Remove, please give reason and effective date (i.e. Birth, Death, Marriage, Divorce and Date) | | | | | | |
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| ❖ STATUS | | | | | | |
| ☐ Single ☐ Married* ☐ Domestic Partner [| ☐ Widowed ☐ Divorced ☐ Dis | solution Domestic Partnership or | | | | |
| Civil Union If status has changed, please provide | e date of event | | | | | |
| | | | | | | |
| | | CHOOSE COVERAGE | | | | |
| ☐ I select the MEDICAL ☐ Select© coverage to the RIGHT ☐ TotalC | <u>=</u> | mployee Only wo Person | | | | |
| (Complete 1, & 2 plus the | F: | amily | | | | |
| Dependent section below) | (Emp | loyee + 2 or more) | | | | |
| Either myself, my spouse, or (one of) my depende | nts is eligible for Medicare Part A and/ | or Part B | | | | |
| PLEASE PROVIDE ALL REQUESTE | ED INFORMATION BELOW AND SIG | N THE NEXT PAGE | | | | |
| ❖ YOU & DEPENDENTS - RELATIONSHIP CODES | : Spouse = SP; Child = CH; Domestic o | r Civil Union Partner = NQP | | | | |
| Fill in your own information on the first line. Your dependents include your spouse, civil union partner, qualified domestic partner, unmarried children under age 26, including children of your civil union or qualified domestic partner. | | | | | | |
| Coverage Election Medical Medica | Person Has Oth are-eligible Insurance | er | | | | |
| Retiree Coverage Y N | Y N Y N | | | | | |
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| Coverage Election Medical Medica | Person Has Oth are-eligible Insurance | er | | | | |
| Name: Y N | | | | | | |
| Relationship: Date of Birth: | | SSN: | | | | |

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| | Medical N | Medicare-eligible Y N Birth: Election | ☐ Male | Insurance | |
| | Medical Y N Date of I | Medicare-eligible Y N Birth: | ☐ Male | Insurance Y N Female | |
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| Relationship: | Medical Y N Date of I Coverage Medical Y N | Medicare-eligible Y N Birth: Election Medicare-eligible | ☐ Male | Insurance Y N Female Person Has Other Insurance | |
| Relationship: | Medical Y N Date of I Coverage Medical Y N | Medicare-eligible Y N Birth: Election Medicare-eligible Y N | ☐ Male | Insurance Y N Female Person Has Other Insurance Y N | , |
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