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**.

SUBMIT the enrollment form with attachments to ***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.

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Retiree Health Benefit
Enrollment Change Form

1. **EMPLOYEE INFORMATION** – (Last, First, M.I)	**EMPLOYEE NO.**
Telephone Number ( ) -	**Personal Email Address**

2. COMPANY ☐CECONY ☐ O&R ☐ Officer

3. MEDICARE STATUS ☐Disable and Under 65 ☐Over 65 Medicare Beneficiary Identifier (MBI) #_____
☐ Not Medicare Eligible

4. ACTION REQUESTED: ☐New Retirement/Dependent ☐ Surviving Spouse ☐ Add Self/Dependent ☐ Drop Self/Dependent

5. QUALFYING LIFE EVENT (Check one)

☐Marriage ☐Divorce
☐Birth/Adoption ☐Death
☐Loss Coverage ☐Gain Coverage

Date of Event _____/_____/_____

6. TYPE and LEVEL OF COVERAGE

☐Employee
☐Employee + 1
☐Family
☐Surviving Spouse

7. HEALTH PLANS

Consolidated Edison	**Orange & Rockland**
Medical/Prescription Drug/Vision ❑ Cigna /CPS Vision ❑ CVS Health ❑ HMO/Managed Choice List: _____	**Medical/Prescription Drug /vison** ❑ Cigna /CVS Health/CPS Optical
Dental ❑ MetLife Basic Plan ❑ MetLife Premium Plan	**Dental** ❑ MetLife Basic Plan ❑ MetLife Premium Plan (Management Only)

8. SPOUSE/DEPENDENT INFORMATION: List eligible dependents and attach required proof of dependency documents

Relationship	First Name	MI	Last Name	Gender (M/F)	DOB MM/DD/CCYY	Social Security #	Disable (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	
❑Spouse ❑Child									❑Under 65 ❑Over 65	
❑ Spouse ❑ Child									❑ Under 65 ❑Over 65	
❑Spouse ❑Child									❑ Under 65 ❑ Over 65	

9. RETIREE SIGNATURE/AUTHORIZATION

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_____/_____/_____