Retiree Benefits Enrollment Form Plan Year 2026 – NTTA

HR Use Only	Data Entry Use Only
Date Rec'd _____	Date Entered_____
Rec'd By _____	Entered By _____

PEBC PUBLIC EMPLOYEE BENEFITS COOPERATIVE

STEP 1 – ENTER RETIREE OR SUBSCRIBER INFORMATION.

Is this an address change? ___ YES ___ NO

Retiree/Subscriber Name (Last, First, Middle Initial)		Social Security Number	Are you enrolled in both Medicare Part A & Part B?
Street Address	City, State, Zip	Home or Cell Phone	Retiree Medicare ID Number

☐ I am enrolling as the retiree ☐ I am enrolling as the surviving spouse of a deceased retiree _____
Deceased retiree name

Email Address_____

STEP 2 – ENROLLMENT EVENT.

Annual Enrollment (coverage effective 1/1/2026)	**New Retiree**
☐ No change from current year (skip to signature line below)	Retirement Date _____ Effective date _____
☐ Change coverage for 2026 (enter selected coverage below)	☐ Add coverage (enter selected coverage below)
☐ I decline all coverage	☐ I decline all coverage

STEP 3 – ENROLLMENT. Enter the information requested for each person enrolling in a medical, dental or vision plan. Line 2 is reserved for spouse; leave blank if spouse is not enrolling in a plan. Indicate if you want to enroll in a medical plan (Yes/No) and then select a dental and/or vision plan. Go to Step 4 to indicate your chosen medical plan. You cannot add new coverage but you can change plans. All must enroll in the same coverage as the retiree and enrollment is subject to dependent and plan eligibility.

ANT = Delta Dental Care USA DHMO Plan **PEB** = PEBC Dental Plan (Delta Dental DPPO) **VIS** = VSP Vision Plan

	Relationship (Self, Spouse, Child, Grandchild)	Retiree/Subscriber Name (Last, First, MI) If address is different than retiree address above, enter address below.	Social Security Number	Date of Birth	Marital Status: Married Single M/S	Gender	**Medical Plan** *enter* **Yes/No** *If Yes, go to Step 4*	**Dental Plan** *enter* **ANT, PEB** or **None**	**Vision Plan** *enter* **VIS** or **None**
1	**Self**		See Above			M / F			
2	**Spouse***					M / F			
3						M / F			
4						M / F			

Spouse Medicare ID Number (if enrolling in MPO or PMA) _____ Email Address_____

STEP 4 - SELECT A MEDICAL PLAN. ***Spouse Medical Plan Surcharge Affidavit required if enrolling spouse in medical plan.**

Retiree enrolled in Medicare Parts A & B *(Required)* regardless of age	**Retiree under age 65**
☐ **MPO –** Blue Cross Group Medicare Advantage **PPO** plan for health care and prescription drug coverage ☐ **MPD*** if non-Medicare dependents enrolled in PPO Plan	☐ **PPO* –** PEBC PPO Plan
☐ **PMA –** Blue Cross Group Medicare Advantage **HMO** plan for health care and prescription drug coverage ☐ **PMD*** if non-Medicare dependents enrolled in PPO Plan	☐ **HDP* –** High deductible plan with HSA (a qualified high deductible health plan) *referred to as the HDP Plan.* Read the information on the back of the form before you enroll.
☐ **I decline medical plan coverage**	☐ **I decline medical plan coverage**

_____ _____ _____ _____

Retiree Signature Date **Spouse Signature** (if enrolling in MPO or PMA) Date

I certify the information above is true and correct, that my covered dependents (if any) are eligible for the plan(s), dependents are subject to validation of documents proving dependent eligibility, ineligible dependents will be removed from the plan(s), and I could be subject to penalties connected to enrollment of an ineligible dependent. I acknowledge that if I enroll my spouse on my medical plan, premium cost could increase based on my spouse's enrollment in his/her employer medical plan and/or my failure to return the Spouse Medical Plan Surcharge Affidavit by the date due. I agree to read my enrollment information and the information found on the back of this form.