2026 Retiree Enrollment / Change Form

October 1, 2025 – September 30, 2026

This form is used to enroll/drop/change the following benefit plans: **Under 65 Retiree Medical**, **Retiree Dental,** and **Retiree Vision.** Failure to return this form within the appropriate timeframe could result in loss of coverage for you and your dependents. All retirees and dependents must provide a Social Security Number to enroll. Rates and plan details are in the Retiree Benefits Guide. Retirees and/or dependents enrolling in a City plan AND who are eligible for Medicare must complete the Medicare Section and provide a copy of their card. Enrollment in **Age 65+ Retiree Medicare** plans is administered by United Healthcare.

Effective Date: _____

Retiree or Surviving Spouse Information

Last Name _____ First Name _____ MI _____

Check One: Retiree _____ Surviving Spouse____

If Surviving Spouse, enter name of Retiree: _____

Address_____ City _____ State _____ ZIP _____

Home Phone Number _____ Work Phone Number _____ Date of Birth: _____

E-mail Address _____ Social Security Number _____

Address Change: Yes / No Gender: Male ____ Female ____ Marital Status: Single ____ Married ____

Retiree Eligibility

Retirees and eligible dependents will be permitted to enroll in retiree insurance offered through the City if the retiree is not eligible for employer group medical coverage through another employer. Retirees eligible for other employer group medical coverage must complete the Waiver section on the back of this form.

☐I am **not** eligible for employer group medical coverage through a current employer. If at any time I become eligible, I understand I must contact the City of Arlington immediately.

Dependents

Medical	Dental	Vision	Action A=Add D=Drop NC= No Change	Name – Please Print (Last, First, MI)	Relationship SP= Spouse D = Daughter S= Son	Social Security Number	Date of Birth

Medicare Coverage

Name (Last, First, Middle Initial)	Eligible Date:	Effective Date:	Medicare Number:	Relationship	Part A: Yes or No	Part B: Yes or No	Part D: Yes or No

Medical

Plan Selection	Select coverage level:	
___ Medical High Deductible Health Plan ___ Medical Copay Plan	___ Retiree Only ___ Retiree & Spouse ___ Retiree & Child(ren) ___ Retiree & Family	___ Spouse Only (Retire is age 65 or older) ___ Surviving Spouse only ___ Surviving Spouse + Child(ren) ___ Waive

I waive medical coverage for: ___ Myself ___ My spouse ___ My dependent children If waiving, you and/or your dependent may only return to coverage if waiving due to other employer group coverage.	Enter Monthly Cost: $_____ Refer to Retiree Benefits Guide.

Dental

Plan Selection	Retiree Only	Retiree + Spouse	Retiree + Child(ren)	Retiree + Family	Waive
Dental Base Plan	___ $15.72	___ $31.20	___ $37.16	___ $57.68	___ Waive
Dental Buy-Up Plan	___ $40.12	___ $77.96	___ $97.36	___ $150.04	___ Waive

I waive dental coverage for: ___ Myself ___ My spouse ___ My dependent children If waiving, you and/or your dependent may only return to coverage if waiving due to other employer group coverage.	Enter Monthly Cost: $_____

Vision

Plan Selection	Retiree Only	Retiree + Spouse	Retiree + Child(ren)	Retiree + Family	Waive
Vision	___ $4.62	___ $9.54	___ $11.28	___ $14.78	___ Waive

I waive vision coverage for: ___ Myself ___ My spouse ___ My dependent children If waiving, you and/or your dependent may only return to coverage if waiving due to other employer coverage.	Enter Monthly Cost: $_____

Total Monthly Payment – Paid Via Monthly ACH

Enter the monthly cost of each plan you have selected:

$_____ + $_____ + $_____ + $_____

Under Age 65 Medical | Dental | Vision | Total Monthly Cost

Form Submission

Forms will only be accepted by email: RetireeBenefits@arlingtontx.gov

Waiver

I understand that as a Retiree, if I waive coverage due to other employer group medical, dental, or vision coverage, I may in the future be able to re-enroll if I give notice and submit required documents within 60 days after such coverage ends. However, if I do not submit for enrollment within 60 days, I will not be permitted to return to coverage, and this is considered a permanent waiver. In addition, if I waive coverage due to enrolling in non-group coverage, this is also considered a permanent waiver.

My signature below affirms that my benefit enrollment includes only those dependents that meet the City of Arlington eligibility guidelines and that all information provided above is true and correct. I understand that any intentional false statement in my enrollment or willful misrepresentation relative thereto may be subject to financial restitution and/or cancellation of all coverage.

Retiree Signature: _____ Date: _____