2026 CITY OF CHARLOTTE RETIREE HEALTH PROGRAM ELECTION FORM

Plans Underwritten by Transamerica Life Insurance Company or Humana, and Express Scripts Medicare

Retiree Information (Please print)			
Name		Date of Birth	
Address		Social Security Number	
City		Gender	Phone Number
State	Zip Code	Medicare ID# *(From Medicare ID card):*	
Hospital (Part A) effective date *(From Medicare ID card):*		Medical (Part B) effective date *(From Medicare ID card):*	
Email Address			
Spouse Information (Please print)			
Name		Date of Birth	
Address		Social Security Number	
City		Gender	Phone Number
State	Zip Code	Medicare ID# *(From Medicare ID card):*	
Hospital (Part A) effective date *(From Medicare ID card):*		Medical (Part B) effective date *(From Medicare ID card):*	
Email Address			

Please Choose Your Coverage	
Retiree or Spouse Only	**Retiree & Spouse**
☐ **Transamerica Retiree Medical Supplement & Express Scripts Prescription Drug Coverage**	☐ **Transamerica Retiree Medical Supplement & Express Scripts Prescription Drug Coverage**
☐ **HUMANA Medicare Advantage PPO & Express Scripts Prescription Drug Coverage**	☐ **HUMANA Medicare Advantage PPO & Express Scripts Prescription Drug Coverage**

Please complete the following information:	
Do you currently have any Medicare Supplement policies or Medicare Advantage Policies in force?	
Retiree/Surviving Spouse (if enrolling):	Spouse (if enrolling):
If YES, with which company?	

*Please note: a permanent U.S. residence address is required to participate in a Medicare Supplement Plan or Medicare Advantage Plan. Medicare Advantage plan participants cannot use a PO Box or Foreign Address.

2026 CITY OF CHARLOTTE RETIREE HEALTH PROGRAM ELECTION FORM

Please complete the following information:	
A couple of questions to help us manage your plan: **If you answered "yes" to this question and you don't need regular dialysis anymore or have had a successful kidney transplant, please attach a note or records from your doctor showing you don't need dialysis or have had a successful kidney transplant.*	**Do you have End-Stage Renal Disease (ESRD)?*** ☐ Yes ☐ No If yes, how long have you been Medicare for ESRD? **Start Date**:___/___/____ **End Date**:___/___/___

FRAUD WARNING

California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.

Fraud Warning:
AR, CO, KY, LA, ME, NM, OH, OK, TN and WA Residents: Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a crime and may be subject to fines or confinement in prison.

MD Residents: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. FRD1000A.MD.

DC Residents: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

NJ Residents: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

PA Residents: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Release of Information:
By joining this medical plan, I acknowledge that my information will be released to Medicare and other plans as is necessary for treatment, payment and health care operations. The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled.

I understand that my signature (or that of the person authorized to act on my behalf under State law where I live) on this application means that I have read and understand the contents of this application. If signed by an authorized individual, this signature certifies that this person is authorized under State law to complete this enrollment and documentation of this authority is available upon request by Medicare.

2026 CITY OF CHARLOTTE RETIREE HEALTH PROGRAM ELECTION FORM

Date:	**Retiree Signature:**
Date:	**Spouse/Surviving Spouse Signature:**

If you are an authorized representative, you must sign above and provide the following information:

Name:_____

Address:_____

Phone Number:_____

Relationship to Retiree:_____

Please return signed election form to:
Amwins Group Benefits
50 Whitecap Drive, North Kingstown, RI 02852

For Customer Service, please call: 1-855-483-5988
Monday through Friday, 8:00 AM to 8:00 PM EST