



2023 Retiree Election Form

Waukesha County Cigna True Choice Medicare (PPO)

You must have Medicare Part A and Medicare Part B to enroll in this plan. I understand this form must be received by Waukesha County Human Resources no later than one month prior to your plan enrollment date.

- I elect the **Cigna True Choice Medicare (PPO)** plan
- I decline the **Cigna True Choice Medicare (PPO)** Plan

Coverage Start Date: _____

Retiree Information

Last name (include surname: Jr., Sr., etc):		First name:	Middle	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.
initial:				
Name must match Medicare health insurance card				
Birth date: ____/____/_____ M M D D Y Y Y Y	Gender: <input type="checkbox"/> M <input type="checkbox"/> F	Telephone: () -	Social Security number: ____-____-____	
Medicare Beneficiary Identifier: ____-____-____-____-____-____		Hospital Part A effective date:		
		Medical Part B effective date:		
Permanent residence street address (P.O. box is not allowed):				
City:	State:	ZIP code:	County:	
Mailing address (only if different from your permanent residence address):				
City:	State:	ZIP code:	County:	
Email address:				
Emergency contact:		Phone number:	Relationship to you:	
Primary Care Physician name:		Primary Care Physician ID#:		

Retiree Signature: _____ Date: _____

Note: Return form to address on next page.

2023 Retiree Election Form



- I elect the Cigna True Choice Medicare (PPO) plan
- I decline the Cigna True Choice Medicare (PPO) Plan

Spouse Information

Last name (include surname: Jr., Sr., etc):		First name:	Middle	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.
initial:				
Name must match Medicare health insurance card				
Birth date: ____/____/_____ M M D D Y Y Y Y	Gender: <input type="checkbox"/> M <input type="checkbox"/> F	Telephone: () -	Social Security number: ____-/____/____	
Medicare Beneficiary Identifier: - - - - - - - - - -		Hospital Part A effective date:		
		Medical Part B effective date:		
Permanent residence street address (P.O. box is not allowed):				
City:	State:	ZIP code:	County:	
Mailing address (only if different from your permanent residence address):				
City:	State:	ZIP code:	County:	
Email address:				
Emergency contact:		Phone number:	Relationship to you:	
Primary Care Physician name:		Primary Care Physician ID#:		

Spouse signature: _____ Date: _____

Please return to:
 Waukesha County
 Human Resources
 515 W. Moreland Blvd AC160
 Waukesha, WI 53188

Phone: (262) 548-7044
 Fax: (262) 896-8272
 Email: HRBenefits@waukeshacounty.gov