## **2023 Retiree Election Form**



# Waukesha County **Cigna True Choice Medicare (PPO)**

Coverage elected below will be effective January 1, 2023.

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 December 1, 2022.

### □ I elect the Cigna True Choice Medicare (PPO) plan

Retiree Information						
Last name (include surname: ) initial:	r., Sr., etc)	): First na	ame:	Middle	□ Mr. □ Mi	rs. □Ms.
Name must match Medicare h	ealth insu	rance card				
Birth date:	Gender:	Telephon	e:	Social Secu	rity number:	
$\frac{1}{M} \frac{1}{M} \frac{1}{M} \frac{1}{D} \frac{1}{D} \frac{1}{Y} \frac{1}{Y} \frac{1}{Y} \frac{1}{Y} \frac{1}{Y}$	□ F	( )	-	/	/	_
Medicare Beneficiary Identifie	er:		Hospital P	art A effective	e date:	
			Medical Pa	art B effective	e date:	
Permanent residence street ac	ldress (P.0	O. box is no	t allowed):			
City:	State	):	ZIP code:	Co	ounty:	
Mailing address (only if differe	ent from y	our permai	nent residenc	e address):		
City:	State	):	ZIP code:	Со	ounty:	
Email address:	ł			I		
Emergency contact:	Ph	one numbe	r:	Relations	ship to you:	
Primary Care Physician name:			Primary Car	e Physician II	D#:	

Retiree Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Note: Return form to address on next page.



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l <b>elect</b> the	Cigna	True	Choice	Medicare		nlan
I elect the	Cigila	ITUE	CHOICE	Medicale	(ГГО)	pian

#### □ I decline the Cigna True Choice Medicare (PPO) Plan

Spouse Information						
Last name (include surname: J	r., Sr., etc]	): Fi	rst nan	ne:	Middle	
initial:	-					$\Box$ Mr. $\Box$ Mrs. $\Box$ Ms.
			_			
Name must match Medicare h		1			I	
Birth date:	Gender:	Tele	phone:		Social Secu	rity number:
	$\square$ M	_				
$\frac{-}{M} \frac{-}{M} \frac{-}{D} \frac{-}{D} \frac{-}{Y} \frac{-}$	□ F	(	)	-	/	/
Medicare Beneficiary Identifie	r:			Hospital Pa	art A effectiv	e date:
				Medical Pa	rt B effective	e date:
Permanent residence street ac	ldress (P.0	0. box	is not a	allowed):		
City:	State	2:	2	ZIP code:	Сс	ounty:
Mailing address (only if differe	ent from y	our pe	ermane	ent residence	e address):	
City:	State	2:	2	ZIP code:	Co	ounty:
Email address:						
Emergency contact:	Ph	one n	umber:		Relations	ship to you:
Primary Care Physician name:			I	Primary Car	e Physician I	D#:

Spouse signature: Date:
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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