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
☐ I **decline** the **Cigna True Choice Medicare (PPO)** Plan

Retiree Information

Last name (include surname: Jr., Sr., etc): First name: Middle initial: Name must match Medicare health insurance card			☐ Mr. ☐ Mrs. ☐ Ms.
Birth date: __ __/__ __/__ __ __ __ M M D D Y Y Y Y	Gender: ☐ M ☐ 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 initial: Name must match Medicare health insurance card			☐ Mr. ☐ Mrs. ☐ Ms.
Birth date: __ __/__ __/__ __ __ __ M M D D Y Y Y Y	Gender: ☐ M ☐ 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