



Retiree Benefits Change Form

To continue coverage, you must complete and return this form to GreenTree Administrators. Please be aware that you are not retired until all forms are signed and returned. If you have any questions please call GreenTree at 409-617-0159.

1. PARTICIPANT INFORMATION **PLEASE PRINT CLEARLY**

Name: (Last) (First) (Middle)

Mailing Address:		SSN:	Date of Birth
City:		Home Phone:	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
State:	Zip Code:	Email address:	

2. REASON FOR CHANGE

Reason for Filling Out Form: (Check which applies) Date of Event: _____

Medicare Entitlement
 Address Change
 Drop CoverageAdd
 Newborn/adopted child(ren)
 Change HRA election

3. MEDICAL BENEFITS OPTIONS	4. DENTAL BENEFITS OPTIONS	5. Medicare Plus Option	6. HRA PAY HEALTH PREMIUM OPTION
<input type="checkbox"/> Retiree Only <input type="checkbox"/> Spouse Only <input type="checkbox"/> Retiree + One <input type="checkbox"/> Retiree + Family <input type="checkbox"/> Decline Coverage	<input type="checkbox"/> Retiree Only <input type="checkbox"/> Spouse Only <input type="checkbox"/> Retiree + One <input type="checkbox"/> Retiree + Family <input type="checkbox"/> Decline Coverage	<input type="checkbox"/> Retiree Only <input type="checkbox"/> Spouse Only	Pay my SNHWF health premium monthly out of my HRA account. <input type="checkbox"/> Yes <input type="checkbox"/> No

7. OTHER INSURANCE INFORMATION (IF APPLICABLE)

Do you or your spouse have Medical, Medicare or other health insurance? Yes No
 If yes, please fill out the remainder of this section and attach a copy of your insurance card.

Name of Insured:	Employer:	Policy Number:
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Insurance Name and Address:	Effective date : _____
Please send copy of Certificate of Creditable Coverage, copy of insurance card and/or copy of award notice for Social Security Disability.	

8. List participants to be covered or removed from the plan. Be aware Retiree must participant in order for dependent(s) to be eligible. (Check the appropriate coverage box for each participant) Individuals who were not covered under the Plan on the date immediately before retirement or the commencement of total disability, or who are subsequently terminated under the Plan, will not be allowed to enter the Plan later during the annual open enrollment period or as described in the section, "Special Enrollment Periods". You must pay any required contributions on a timely basis in order to continue participation. If you choose to cancel your coverage at any time, your dependent(s) will no longer bon eligible to remain on the Plan

Retiree Name:	<input type="checkbox"/> Medicare Plus Plan	<input type="checkbox"/> Regular Plan	<input type="checkbox"/> Dental Plan	<input type="checkbox"/> Decline
Spouse Name:	<input type="checkbox"/> Medicare Plus Plan	<input type="checkbox"/> Regular Plan	<input type="checkbox"/> Dental Plan	<input type="checkbox"/> Decline
Dependent:	N/A	<input type="checkbox"/> Regular Plan	<input type="checkbox"/> Dental Plan	<input type="checkbox"/> Decline
Dependent:	N/A	<input type="checkbox"/> Regular Plan	<input type="checkbox"/> Dental Plan	<input type="checkbox"/> Decline
Dependent:	N/A	<input type="checkbox"/> Regular Plan	<input type="checkbox"/> Dental Plan	<input type="checkbox"/> Decline

Medical Premium : _____	Dental Premium: _____
Medical Premium Spouse: _____ (If applicable)	Dental Premium Spouse: _____ (If applicable)

DISABILITY RETIREE: If you are a disability retiree please submit a copy of your Social Security Award Notice within the next 30 days. We will need this in order to flag the system as to when Medicare becomes primary. Medicare becomes primary 24 to 29 months after Social Security deems you disabled whether or not you enroll in Medicare Part A and B. Claims will be paid as if you are enrolled, so please be sure to enroll in Medicare Part B. If you do not enroll in Medicare Part B you will be responsible for Medicare B portion as well as Sabine Neches plan deductibles and out-of-pocket expense. Once you receive your Medicare Part A and B card , please send us a copy for our files.

REGULAR RETIREE: Please send us a copy of your Medicare Part A and Part B card for our files.

Retiree or Spouse With Other Coverage: If you or your spouse has other coverage through Medicare, Medicaid or Insurance Carrier, please send us a copy of Medicare Card, Insurance Card or a Certificate of Creditable Coverage. We will need this information to coordinate benefits with other insurance. Information needs to include Participant(s) name, Company Name, what type of plan and effective date of coverage.

9. HRA ACCOUNT PAY-MY-PROVIDER FOR SNH&W FUND AUTHORIZATION AND RETIREE SIGNATURE

My signature below affirms that all information and statements on this form are full, complete and true to the best of my knowledge. I understand that any misrepresentation on this document may result in my coverage being void as of its effective date with no benefits payable. I understand that these elections will remain in effect until I make a new election due to a qualified family status change or a life status change. I further understand that I may be required to provide proof of a dependent's continuing eligibility for benefits coverage. I authorize Sabine Neches Health & Welfare Plan, GreenTree Administrators, healthcare providers, and stop loss carriers to release information as permitted by law regarding related health and/or coverage information. I further authorize GreenTree Administrators to deduct from my HRA account my month health premiums. (if election was made to do so.)

_____ I understand and agree that payment is due on the first of every month.

_____ I understand that I must notify GreenTree Administrators if I have any change in address or marriage status.

_____ I understand and agree that if I fail to make my payments, Sabine-Neches will cancel my coverage and that I will be ineligible to participate at a later date.

_____ I understand that if I decline coverage at this time I will be ineligible to participate in the plan at a later date.

_____ I understand that if I decline coverage, this also makes my dependent(s) ineligible to remain on the plan.

_____ I understand that my spouse or myself must be enrolled in Medicare Part A & Part B to be eligible for the supplemental plan at age 65.

Retiree Signature: _____

Date: _____

Spouse Signature: _____

Date: _____

GTA Use Only:

_____ LMX _____ HRA

_____ S/C _____ SSN Award Letter

_____ COBRA

_____ Database