2024 Retiree Election Form

MIAMIBEACH

City of Miami Beach
Cigna True Choice Medicare Advantage (PPO)

Coverage elected below will be effective **January 1, 2024.**

You must have Medicare Part A and Medicare Part B to enroll in this plan. I understand this form must be received by Retiree First by October 31, 2023.

☐ I **elect** the **Cigna True Choice PPO** plan ☐ I **decline** the **Cigna True Choice PPO** Plan

Retiree Information

Name must match Medicare health insurance card Last name (include surname: Jr., Sr., etc.): _____ First name: _____ Middle initial:_____			☐ 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 Information:

Name:_____ Phone number: _____

Relationship: _____

Retiree Signature: _____ Date: _____

Please return to:

RetireeFirst
Enrollment Team
1000 Midlantic Dr Ste 100
Mount Laurel, NJ 08054

Phone: (855) 460-6970
Fax: 856-437-4550

2024 Spouse/Dependent Election Form

MIAMIBEACH

City of Miami Beach
Cigna True Choice Medicare Advantage (PPO)

Coverage elected below will be effective **January 1, 2024.**

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☐ I **elect** the **Cigna True Choice PPO** plan ☐ I **decline** the **Cigna True Choice PPO** Plan

Spouse/Dependent Information

Name must match Medicare health insurance card of the Spouse/Dependent Last name (include surname: Jr., Sr., etc.): _____ First name: _____ Middle initial:_____			☐ 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 Information:

Name:_____ Phone number: _____

Relationship: _____

Retiree Signature:_____ Date:_____

Please return to:

RetireeFirst
Enrollment Team
1000 Midlantic Dr Ste 100
Mount Laurel, NJ 08054

Phone: (855) 460-6970
Fax: 856-437-4550