2024 Retiree Election Form

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						\square I decline the Cigna True Choice PPO Plan				
Retiree Information										
Name must match Medicare	healt	th ins	surar	ice ca	rc	l				
Last name (include surname: J	r., Sr.,	, etc.)):				<u></u>		☐ Mr. ☐ Mrs.	
First name:								☐ Ms.		
Birth date:	Gend		Tele	phone:			Social Security number:		ıber:	
$\begin{array}{ c c c c c c c c c c c c c c c c c c c$	□ M □ F		()		-	//			
Medicare Beneficiary Identifier:						Hospital Part A effective date:				
— — — — — — — Medical Part B effective da						tive date:				
Permanent residence street ad	dress	s (P.C). box	is not	a	llowed):				
City:		State:			ZIP code:			County:		
Mailing address (only if differe	nt fro	om yo	our pe	erman	eı	nt residence	e address):		
City:		State:			ZIP code:		County:			
Email address:										
Emergency Contact Informatio	n:									
Name:				Phone	e r	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



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 P		☐ I decline the Cigna True Choice PPO Plan						
Spouse/Dependent Information								
Name must match Medicare	health in	surance ca	ır	d of the Spo	ouse/Dep	endent		
Last nama (in aluda aumama. I	n Cn ota	١.					☐ Mr.	
Last name (include surname: J	1., SI., etc.	J:					☐ Mrs. ☐ Ms.	
First name:	Middle initial:					□ MS.		
Birth date:	Gender:	Telephone	e:		Social Security number:		iber:	
$\frac{1}{M} \frac{1}{M} \frac{1}{D} \frac{1}{D} \frac{1}{Y} \frac{1}{Y} \frac{1}{Y} \frac{1}{Y}$	□ M □ F	()		-	//			
Medicare Beneficiary Identifie		Hospital Part A effective date:						
				Medical Part B effective date:				
Permanent residence street ad	ldress (P.0	O. box is not	t a	llowed):				
City:) :	Z	ZIP code:		County:		
Mailing address (only if differe	ent from y	our permar	ne	nt residenc	e address):		
City:	State):	Z	IP code:		County:		
Email address:								
Emergency Contact Information	n:							
Name: Phone number:								
Relationship:								
Retiree Signature:				Da	te:			

Please return to:

RetireeFirst Enrollment Team 1000 Midlantic Dr Ste 100 Mount Laurel, NJ 08054 Phone: (855) 460-6970 Fax: 856-437-4550