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|---|------------|---------------------------|--------|-----------------------------|------------------------|------------------|--|
| Retiree's Date of Retirement: | | | | Plant Retiree Retired From: | | | |
| Retiree/Surviving Spouse Information | | | | | | | |
| LAST NAME | FIRST NAME | M.I. | GENDER | DATE OF BIRTH | SOCIAL SECURITY NUMBER | | |
| | | | M F | | - - | | |
| ADDRESS | | APT # | CITY | STATE | ZIP CODE | TELEPHONE NUMBER | |
| | | | | | | () | |
| COUNTY OF RESIDENCE: | | | | | | | |
| Is this a change in address? YES NO | | EFFECTIVE DATE OF CHANGE: | | | MEDICARE # | | |

| Dependent Information | | | | | | | | |
|------------------------------|-----------|------------|------|--------|---------------|------------------------|------------|-----------------------|
| RELATIONSHIP | LAST NAME | FIRST NAME | M.I. | GENDER | DATE OF BIRTH | SOCIAL SECURITY NUMBER | CHANGE | STATUS CHANGE REASON* |
| Spouse | | | | M F | | - - | Add Delete | |
| MEDICARE # | | | | | | | | |
| Dependent | | | | M F | | - - | Add Delete | |
| Dependent | | | | M F | | - - | Add Delete | |
| Dependent | | | | M F | | - - | Add Delete | |

* Retirement or a change in status will require documentation of the reason for the change - See reverse for definition of a change in status, and required documentation.

Benefit Plan Information

- NON-MEDICARE MEMBERS**
- National BCBS PPO
 - Catastrophic National BCBS PPO (Members with less than 95 points)

- MEDICARE MEMBERS**
- Freedom Blue PPO**
 - Catastrophic Freedom Blue PPO** (Members with less than 95 points)

****Please complete the additional information on the back of this form. You must complete this form for each Medicare eligible Member**

Waiver of Coverage
 I do not wish to elect coverage through the Health Care Trust

I understand that if I elect to waive or terminate coverage with the Health Care Trust I will not be permitted to re-enroll until the next annual enrollment, unless I experience an involuntary loss of other group health insurance coverage.

Retiree/Surviving Spouse Signature: _____ Date: _____

Spouse/Dependent Signature: _____ Date: _____

WHEN MAKING ADDITIONS OR CHANGES FOR THE GOODYEAR RETIREE HEALTH CARE TRUST – YOU MUST SUBMIT ADDITIONAL INFORMATION LISTED ON THE BACK OF THIS FORM.

Documents are not returned, please do not send originals

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| FREEDOM BLUE: | |
| Members enrolled in both Medicare Part A and Part B wishing to enroll in Freedom Blue PPO: Please answer the following questions. Failure to answer these questions will delay your enrollment into Freedom Blue PPO | |
| 1.) Do you have End-Stage Renal Disease? | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| If you answer "YES" to this question and you don't need regular dialysis anymore, or if you have had a successful kidney transplant, please attach a note or records from your doctor showing you don't need dialysis or have had a successful kidney transplant. | |
| 2.) Are you enrolled in your State Medicaid program? | <input type="checkbox"/> YES If YES, Medicaid Number: _____ <input type="checkbox"/> NO |
| 3.) Are you a resident in a long term care facility such as a nursing home? | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| If YES, Please provide the following information: Name of Institution: _____ Address and Phone Number of Institution (number and street): _____ | |

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| STATUS CHANGE: | |
| You can change some of your elections during the plan year if you have a family status change and submit this form within 31 days. A change in family status is defined below. PLEASE CHECK THE appropriate box below that applies. | |
| Status Change: | Documents: |
| <input type="checkbox"/> Your marriage or divorce; | Marriage: Marriage Certificate; Divorce: Divorce Decree |
| <input type="checkbox"/> The birth or adoption of your child; | Birth Certificate or Adoption paperwork |
| <input type="checkbox"/> The death of your spouse or child; | Death Certificate |
| <input type="checkbox"/> A dependent satisfying the requirements for unmarried dependents; | See below |
| <input type="checkbox"/> A change in your, your spouse's or dependent's employment status | Proof of involuntary loss of other coverage |
| <input type="checkbox"/> Medicare Entitlement | Medicare Card |

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| RETIREMENT PROCESSING: | |
| To Add: | Spouse: Marriage Certificate or current year Federal Income Tax Return, showing married filing jointly or married filing separately |
| | Dependent Children: |
| | <ul style="list-style-type: none"> • Natural Child: Birth Certificate listing Retiree as parent • Adopted Child: Certificate of Adoption • Step Child: Birth Certificate listing Spouse as parent (additional information required, please see Proof of Other Children below) • Legal Guardianship: Legal Guardianship Papers (additional information required, please see Proof of Other Children below) |
| | Children age 19 to 25 |
| | <ul style="list-style-type: none"> • Current year Federal Income Tax Return showing child as dependent & Proof of full-time student status |
| | Disabled Child over age 19 |
| | <ul style="list-style-type: none"> • Current year Federal Income Tax Return showing child as dependent and Child's tax return if employed & Disabled Dependent Certification Form (contact Healthcare Trust Administrative Office for form) |
| | Proof of Other Children (Step Children and Legal Guardianship) |
| | <ul style="list-style-type: none"> • Current year Federal Income Tax Return showing child as dependent and Child's current year Federal Income Tax Return if employed • Affidavit of full-time residency and verification of child's home address* |
| | <i>*In the case of a divorce, the requirement for full-time residence with the Retiree may be waived if the divorce decree indicates that the Retiree is not responsible for physical custody. However the child must still be claimed on the Retiree's federal tax return to be eligible.</i> |