GOODYEAR
RETIREE HEALTH CARE TRUST

2021 Enrollment Election and/or Change Form

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.

RETURN THIS FORM TO: GOODYEAR RETIREE HEALTH CARE TRUST
60 BOULEVARD OF THE ALLIES, FIFTH FLOOR, PITTSBURGH, PA 15222
Phone: (866) 694-6477 Fax: (412) 224-4465 E-mail: GRTrust@cdsadmin.com

Documents are not returned, please do not send originals

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

NAME OF MEDICARE ELIGIBLE PARTICIPANT:

1.) Do you have End-Stage Renal Disease? ☐ YES ☐ NO

2.) Are you enrolled in your State Medicaid program? ☐ YES If YES, Medicaid Number: _____ ☐ NO

3.) Are you a resident in a long term care facility such as a nursing home? ☐ YES ☐ NO

If YES, Please provide the following information:

Name of Institution: _____

Address and Phone Number of Institution (number and street): _____

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:
☐	Your marriage or divorce;	Marriage: Marriage Certificate; Divorce: Divorce Decree
☐	The birth or adoption of your child;	Birth Certificate or Adoption paperwork
☐	The death of your spouse or child;	Death Certificate
☐	A dependent satisfying the requirements for unmarried dependents;	See below
☐	A change in your, your spouse's or dependent's employment status	Proof of involuntary loss of other coverage
☐	Medicare Entitlement	Medicare Card

RETIREMENT PROCESSING:

To Add:

Spouse:

Marriage Certificate or current year Federal Income Tax Return, showing married filing jointly or married filing separately

Dependent Children:

- 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

- Current year Federal Income Tax Return showing child as dependent & Proof of full-time student status

Disabled Child over age 19

- 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

- 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*

**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.*