

Retiree Enrollment Form (page 2) Plan Year 10/01/2006 – 09/30/2007	Name: _____
	Ein: _____

MEDICAL COVERAGE CHOICES (Continued)

If you are currently enrolled in the Retiree Group Medical Plan

Please indicate your choice of medical plan and select the coverage level you wish to enroll for by checking the appropriate box.

MEDICARE ELIGIBLE – IN AREA

If you and your spouse both have Medicare Part B

Advantra – Medicare HMO – In Area – Eligible Counties

Plan Code	Description	Cost/Month
<input type="checkbox"/> GRRG	Retiree Only Medicare Eligible	\$66.00
<input type="checkbox"/> GSSG	Retiree Plus Spouse Both Medicare Eligible	\$132.00

Gold Advantage – Medicare HMO – In Area – Eligible Counties

<input type="checkbox"/> GRRGC	Retiree Only Medicare Eligible	\$35.00
<input type="checkbox"/> GSSGC	Retiree Plus Spouse Both Medicare Eligible	\$70.00

Medicare Complete – Medicare HMO – In Area – Eligible Counties

<input type="checkbox"/> URRU	Retiree Only Medicare Eligible	\$.00
<input type="checkbox"/> USSU	Retiree Plus Spouse Both Medicare Eligible	\$.00

NON-MEDICARE ELIGIBLE – IN AREA

GHP Basic Plan

<input type="checkbox"/> GH1HR	Retiree Only	\$255.76
<input type="checkbox"/> GH2HR	Retiree and 1 Dependent	\$501.30
<input type="checkbox"/> GH3HR	Retiree and Family	\$716.12

GHP Primary POS Plan

<input type="checkbox"/> GA1HR	Retiree Only	\$400.60
<input type="checkbox"/> GA2HR	Retiree and 1 Dependent	\$785.16
<input type="checkbox"/> GA3HR	Retiree and Family	\$1,121.66

GHP Primary PPO SELECT Plan (Plan does not include the BJC Network)

<input type="checkbox"/> GA1CR	Retiree Only	\$338.16
<input type="checkbox"/> GA2CR	Retiree and 1 Dependent	\$662.78
<input type="checkbox"/> GA3CR	Retiree and Family	\$946.82

GHP Comprehensive POS Plan

<input type="checkbox"/> GO1HR	Retiree Only	\$524.98
<input type="checkbox"/> GO2HR	Retiree and 1 Dependent	\$1,028.94
<input type="checkbox"/> GO3HR	Retiree and Family	\$1,469.92

GHP Comprehensive PPO SELECT Plan (Plan does not include the BJC Network)

<input type="checkbox"/> GO1CR	Retiree Only	\$443.14
<input type="checkbox"/> GO2CR	Retiree and 1 Dependent	\$868.56
<input type="checkbox"/> GO3CR	Retiree and Family	\$1,240.80

(OVER)

Retiree Enrollment Form (page 3)

Plan Year 10/01/2006 – 09/30/2007

Name: _____

Ein: _____

MEDICAL COVERAGE CHOICES (Continued)**If you are currently enrolled in the Retiree Group Medical Plan**

Please indicate your choice of medical plan and select the coverage level you wish to enroll for by checking the appropriate box.

MEDICARE ELIGIBLE – OUT OF AREA

Plan Code	Description	Cost/Month
GHP Out of Area Plan		
<input type="checkbox"/>	GRRHA 1 Only Medicare Eligible	\$314.88
<input type="checkbox"/>	GSSHA 2 Both Medicare Eligible	\$564.78
<input type="checkbox"/>	GTTHA 1 Medicare Eligible Plus 1 Non-Medicare Eligible	\$721.52
<input type="checkbox"/>	GMMHA 2 Medicare Eligible Plus 1 or more Non-Medicare Dependents	\$690.36
<input type="checkbox"/>	GFFHA 1 Medicare Eligible Plus 2 or more Non-Medicare Dependents	\$881.68

NON-MEDICARE ELIGIBLE – OUT OF AREA**GHP Out of Area Plan**

<input type="checkbox"/>	GA1HO Retiree Only	\$401.90
<input type="checkbox"/>	GA2HO Retiree and 1 Dependent	\$787.70
<input type="checkbox"/>	GA3HO Retiree and Family	\$1,125.26

IF YOU WISH TO CANCEL YOUR MEDICAL COVERAGE WITH THE ST. LOUIS COUNTY RETIREE GROUP *

CNXL Cancel All Medical Coverage with the St. Louis County Retiree Group

*** IMPORTANT** – I UNDERSTAND IF I CANCEL ANY COVERAGE (MEDICAL-DENTAL-VISION), I CAN NEVER RE-ENROLL IN THAT COVERAGE THROUGH THE ST. LOUIS COUNTY GROUP AND THAT CHANGES MADE TO THE GROUP COVERAGE MAY AFFECT THE TERMS AND CONDITIONS OF THE AVAILABLE OPTIONS.

(OVER)

Retiree Enrollment Form (page 4)	Name: _____
Plan Year 10/01/2006 – 09/30/2007	Ein: _____

DENTAL CHOICES

If you are currently enrolled in the Retiree Group Dental Plan

Please indicate your choice of dental plan and select the coverage level you wish to enroll for by checking the appropriate box.

Plan Code	Description	Cost/Month
Cigna Dental Care DHMO		
<input type="checkbox"/> HCIC	Retiree Only	\$13.06
<input type="checkbox"/> HCDC	Retiree and 1 Dependent	\$24.50
<input type="checkbox"/> HCFC	Retiree and Family	\$31.82
<input type="checkbox"/> CANCEL	Cancel all coverage Cigna Dental DHMO *(see Important notation above)	

Cigna Dental PPO

<input type="checkbox"/> PCIC	Retiree Only	\$30.70
<input type="checkbox"/> PCDC	Retiree and 1 Dependent	\$61.40
<input type="checkbox"/> PCFC	Retiree and Family	\$92.10
<input type="checkbox"/> CANCEL	Cancel all coverage Cigna Dental PPO *(see Important notation above)	

VISION CHOICES

If you are currently enrolled in the Retiree Group Vision Plan

Please indicate your choice of vision plan and select the coverage level you wish to enroll for by checking the appropriate box.

Plan Code	Description	Cost/Month
EyeMed Vision		
<input type="checkbox"/> CMVIC	Retiree Only	\$5.80
<input type="checkbox"/> CMVDC	Retiree and 1 Dependent	\$11.60
<input type="checkbox"/> CMVFC	Retiree and Family	\$16.22
<input type="checkbox"/> CANCEL	Cancel all coverage EyeMed Vision * (see Important notation above)	

I the undersigned, do herewith request and authorize St. Louis County to deduct monthly from my St. Louis County retirement benefit, such amount as may be necessary to pay medical insurance premiums for the type of membership checked below. I understand that if changes are made to the group coverages, this may affect the terms and conditions of the available options.

SIGNATURE: _____ DATE: _____ EIN: _____

EFFECTIVE DATE: _____

MEDICAL CODE _____ DENTAL CODE _____ VISION CODE: _____