City of Newport News
Employees' Retirement Fund
2400 Washington Avenue
Newport News, VA 23607
(757) 926-3929
(757) 926-3548 Fax

Retiree Benefit Change Form

Retiree Name ______ Social Security # or EIN ______ Phone Number ______

HEALTH INSURANCE *

☐ Change Health Plan to *(may only be changed during open enrollment)*: ☐ POS 750 ☐ POS 1500 ☐ Equity HDHP

☐ Terminate Health Insurance Completely *(please list all family members on your plan, then skip to signature section)*

______

☐ Terminate Dependent Only *(fill out info below):*

Name of Dependent to be Removed: ______

Relationship of Dependent: ☐ Spouse ☐ Child

Reason for Termination: ☐ Aged Out ☐ Has Own Coverage ☐ Other ______

Coverage Level after Change:
☐ Single
☐ Single/Spouse
☐ Single + 1 Child
☐ Family

Finance Use Only

☐ Changed at Carrier ______ ☐ Changed in Pension System ______

DENTAL INSURANCE *

☐ Terminate Dental Insurance Completely *(skip to signature section)*

☐ Terminate Dependent Only *(fill out info below):*

Name of Dependent to be Removed: ______ Relationship: ☐ Spouse ☐ Child

Coverage Level after Drop: ☐ Single ☐ Single + 1 ☐ 3 or more

Finance Use Only
Changed at Delta ______

VISION INSURANCE *(may only be added or cancelled during open enrollment)*

☐ New enrollment *(please list all family members on your plan):*

______

☐ Terminate Vision Insurance Completely *(skip to signature section)*

☐ Terminate Dependent(s) Only (*please list name of dependent(s) to remove*): ______

Coverage Level: ☐ Single ☐ Single + 1 ☐ Family

SIGNATURE *(Required for any changes to be made)*

Health & Dental Insurance: Per city policy, there is **no reinstatement available for these insurances if cancelled.*

Signature ______ Date ______ **Effective Date for Changes** ______