

RCUH Retiree Group Health and Life Insurance Enrollment (B-27)

(for new enrollments or changes to enrollment for qualified individuals as defined in RCUH [Policy 3.550](#))

Email completed form to RCUH Benefits at rcuh_benefits@rcuh.com or contact us at (808) 956-3100.

SECTION 1: Retiree Information

Mailing Address:

Email Address:

Annuitant of the RCUH Group Retirement Annuity (TIAA GRA) Plan Effective:

Are you eligible for Medicare Parts A & B? **No** **Yes**

Are you enrolled in Medicare Parts A & B? **No** **Yes**

Part A (Hospital) Effective Date:

Part B (Medical) Effective Date:

Medicare Claim Number: _____

Do you have other coverage? **No** **Yes (name of carrier):** _____

SECTION 2: Retiree Health Insurance RCUH Policy 3.520 RCUH Retirees are responsible for timely monthly premium payments directly to respective carriers *If enrolling qualified dependents, please complete Section 3.

For RCUH Retirees Non-Medicare-eligible:

	Enroll/ Cancel	Employee	Qualified Dependent
HMSA Comprehensive Medical Basic (COMPB)			
HMSA Comprehensive Medical (COMP)			
HMSA Preferred Provider (PPO)			
HMSA HMO (HPH) Hawaii Residents only			
Kaiser Plan B (Plan B) Hawaii Residents only			

For RCUH Retirees Medicare-eligible and enrolled:

	Enroll/ Cancel	Employee	Qualified Dependent
HMSA Akamai Advantage			
Kaiser Senior Advantage			

RCUH Retiree Group Health and Life Insurance Enrollment (B-27)

(for new enrollments or changes to enrollment for qualified individuals as defined in RCUH [Policy 3.550 RCUH Retiree Health and Life Insurance Program](#))

Email completed form to RCUH Benefits at rcuh_benefits@rcuh.com or contact us at (808) 956-3100.

SECTION 3: Dependent Information PROOF OF RELATIONSHIP DOCUMENTATION IS REQUIRED when adding a dependent upon submission (i.e., Marriage Certificate, Civil Union Certificate) and subject to RCUH review.

ADD/ REMOVE	Med	NAME (Last,First)	Social Security Number	Date of Birth	Relation- ship	Gender

SECTION 4: Life Insurance Enrollment and Beneficiary Designation ELIGIBILITY SUBJECT TO RCUH HR REVIEW. NOTE: Refer to RCUH Policy 3.540 for details on the RCUH Retiree Life Insurance Plan.

ENROLL(if eligible)

Primary/ Secondary	NAME (Last,First)	Mailing Address	Email Address	Relationship

SECTION 5: RCUH Employee/Retiree Signature

I have read and agree to the eligibility requirements for participating in the RCUH Retiree Health and Life Insurance Program. I certify that I am currently an annuitant with the RCUH Group Retirement Annuity (TIAA GRA) plan and will remain so while I am receiving these benefits. Information in this application is given to obtain insurance and is true and complete to the best of my knowledge and belief. I authorize my employer to set my effective dates of coverage. I agree to abide by the provisions of the service agreement and health plan regulations.

Applicant Signature: _____

SECTION 6: RCUH Human Resources Approval

Retiree Health + Life Insurance

Retiree Health Only

Not qualified

New Enrollment Change Enrollment Cancel Enrollment

Signature _____ Date:
RCUH Director of Human Resources or Designee

~~~~~  
For RCUH HR Internal Use only

Years of continuous Service  
Termination Date  
Termination in Good Standing

Age at time of application  
10 Years GRA  
10 Years Group Life Insurance  
Annuitant

RCUH Retiree Eligibility qualified by: