Syracuse University
Human Resources

Retiree Medical Election Form

hrservice@syr.edu

The Retiree Medical Election Form allows Syracuse University retirees and dependent(s) the ability to elect retiree medical coverage. All retirees wishing to elect or continue retiree medical coverage must fill out and complete this form within 31 days of the later of your retirement date or the date of the cover letter that accompanied these enrollment forms.

Please return the completed form to Lifetime Benefit Solutions, Inc. at the following address:

Lifetime Benefit Solutions, Inc.
P.O. Box 332
Liverpool, NY 13088

Section 1: Eligible Retiree's Personal Information

Name: _____
(Last, First, Middle Initial)

Mailing Address: _____

City, State and Zip: _____

SU ID Number: _____

Email Address: _____ Daytime Phone Number: _____

Date of Birth: _____

Section 2: Select Coverage Effective Date

☐ Please start my retiree medical coverage as of my retirement date

For Retirees Eligible for the Opt Out Provision:

☐ Please opt me out of health coverage until a later date (the attached Opt Out Form will need to be completed)

Section 3: Select a Retiree Medical Plan Option

☐ SUBlue ☐ SUOrange ☐ SUPro

Section 4: Eligible Dependent's Personal Information

(Additional fields are provided below for multiple dependents, if applicable)

Eligible Dependent's Name: _____
(Last, First, Middle Initial)

Relationship to Retiree: _____

Home Address: _____

City, State, and Zip: _____

Social Security Number: _____ Date of Birth: _____

Daytime Phone Number: _____

Eligible Dependent's Name: _____
(Last, First, Middle Initial)

Relationship to Retiree: _____

Home Address: _____

City, State, and Zip: _____

Social Security Number: _____ Date of Birth: _____

Daytime Phone Number: _____

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Eligible Dependent's Name: ______________________________
(Last, First, Middle Initial)
Relationship to Retiree: ______________________________
Home Address: ______________________________
City, State, and Zip: ______________________________
Social Security Number: ______________ Date of Birth: ______________
Daytime Phone Number: ______________

Eligible Dependent's Name: ______________________________
(Last, First, Middle Initial)
Relationship to Retiree: ______________________________
Home Address: ______________________________
City, State, and Zip: ______________________________
Social Security Number: ______________ Date of Birth: ______________
Daytime Phone Number: ______________

Eligible Dependent's Name: ______________________________
(Last, First, Middle Initial)
Relationship to Retiree: ______________________________
Home Address: ______________________________
City, State, and Zip: ______________________________
Social Security Number: ______________ Date of Birth: ______________
Daytime Phone Number: ______________

Eligible Dependent's Name: ______________________________
(Last, First, Middle Initial)
Relationship to Retiree: ______________________________
Home Address: ______________________________
City, State, and Zip: ______________________________
Social Security Number: ______________ Date of Birth: ______________
Daytime Phone Number: ______________

Retiree's Signature: ______________________________ **Date:** ______________

Lifetime Benefit Solutions, Inc. : Internal Use Only

☐ Approval Date: ______________ ☐ Denial Date: ______________ Reason: ______________