Syracuse University
Human Resources

Retiree Medical Election Form

hrservic@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 POMCO at the following address:

POMCO
P.O. Box 159
Syracuse, NY 13206-0159

Section 1: Eligible Retiree's Personal Information

Name: _____
(Last, First, Middle Initial)

Mailing Address: _____

City, State and Zip: _____

Employer Name: _____ SU ID Number: _____

Email Address: _____ Daytime Phone Number: _____

Date of Birth: _____

☐ Check whether you wish to apply the VSIP subsidy toward your own coverage

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: _____

☐ Check if you wish to apply the VSIP subsidy toward this dependent's coverage

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: _____

☐ Check if you wish to apply the VSIP subsidy toward this dependent's coverage

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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: ____________________

☐ Check if you wish to apply the VSIP subsidy toward this dependent's coverage

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: ____________________

☐ Check if you wish to apply the VSIP subsidy toward this dependent's coverage

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: ____________________

☐ Check if you wish to apply the VSIP subsidy toward this dependent's coverage

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: ____________________

☐ Check if you wish to apply the VSIP subsidy toward this dependent's coverage

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

POMCO's Internal Use Only

☐ Approval Date: ________________ ☐ Denial Date: ________________ Reason: ________________