## Health & Wellness



## **Retiree Medical Plan Change Form**

If you are switching medical plans, complete the information below and sign the form. Your signature on this form will give New York Power Authority permission to change your medical plan.

If you are switching to an HMO\*, you will also need to complete and submit an HMO enrollment form for the applicable plan, which are available on our webpage at www.nypa.gov/benefits/retirees.

| Please change my medical plan from(name of current plan)                             |   |                              |                           |                                     |   |  |
|--|---|------------------------------|---------------------------|-------------------------------------|---|--|
| To:  | UHC PPO Plan or UHC NYPA Plan   |                              |                           |                                     |   |  |
|  |   | UHC Medicare Advantage Plan  |                           |                                     |   |  |
|  |   |                              |                           |                                     |   |  |
| CDPHP* (Capital District, Central NY, Dutchess, Jefferson, Lewis, St. Lawrence Count |   |                              |                           |                                     |   |  |
|  | ☐ Independent Health Active* (Buffalo, Niagara area) ☐ Independent Health Family* (Buffalo, Niagara area) |                              |                           |                                     |   |  |
|  |   |                              |                           |                                     |   |  |
|  | Independent Health Medicare Advantage* (Buffalo, Niagara area)  |                              |                           |                                     |   |  |
| REAS   |   | Vaive Coverage<br>DR CHANGE: | Open Enrollment           | Other                               |   |  |
| Please   | drop  | the following de             | ependents:                |                                     |   |  |
| DROP   |   | Name:                        |                           | DOB:                                |   |  |
| DROP   |   | Name:                        |                           | DOB:                                |   |  |
| I am av  | ware th   | nat this change w            | ill become effective on _ | (date)                              |   |  |
| Daytime Phone:   |   |                              |                           | Email Address:                      | _ |  |
|  | (prin   | nt name)                     |                           | (signature) -type your name- (date) |   |  |

## Return the completed form(s) to:

Mail: HR Services - New York Power Authority, 123 Main Street, Mailstop 4G, White Plains, NY 10601

Email: Retirees@NYPA.gov