PRE 65 RETIREE BENEFITS APPLICATION

OFFICE USE ONLY
Retiree date:
Active insurance ends:
Retiree insurance begins:

Section 1 - Retiree Information

Name: _____ **Date of Birth:** _____
(Last, First, M.I.)

Social Security#: _____-_____-_____ **Marital Status:** ☐ Single ☐ Married ☐ Divorced ☐ Widowed
Mailing Address: _____ **Apt #:** _____
City: _____ **State:** _____ **Zip:** _____ **Phone:** _____

Section 2 - Benefit Selections

***Health Insurance** (Check One)*

☐ Florida Health Care HMO ☐ Florida Health Care HMO 2 ☐ Florida Health Care POS

***Health Coverage for**:* ☐ Retiree Only ☐ Retiree/Spouse ☐ Retiree/Child(ren) ☐ Retiree/Family ☐ Spouse Only

Section 3 - Dependent Information

Relationship	*Last Name*	*First Name*	*M*	*Social Security*	*Sex*	*Date of Birth*
Spouse						
Dependent Child						
Dependent Child						
Dependent Child						

Section 4 - Signature

I represent that the statements on this application are true and complete to the best of my knowledge and belief. I understand and agree that misrepresentations, omissions, concealment of facts, or incorrect statements may result in denial of benefits and/or termination of coverage/membership. I agree to be bound by the group contract's terms and conditions.

_____ _____
Signature Date

SEND FORMS TO FHCP ENROLLMENT DEPT
Email: lward@fhcp.com
Fax: 386-676-7137
Mail: Florida Health Care Plans
Attn: Leslie Ward
PO Box 9910
Daytona Beach, FL 32120

Questions about your pre 65 VCS retiree health insurance, email lward@fhcp.com or call at 386-676-7100 Ext 7688