



Retiree, Surviving Dependent, Retirement Credit Eligible, & LTD Enrollment/Change Form

Check Status: Retirement Credit Eligible LTD Retiree Surviving Dependent

Are you being billed monthly for benefit premiums (i.e., premiums not taken out of your retirement check)? Yes No

Are you? Enrolling or changing medical, dental or vision plan coverage, complete sections A, B, D, E, and G.
 Enrolling or changing health care reimbursement account (through COBRA), complete sections A, B, F and G.
 Reducing life insurance coverage, complete sections A, B, C, and G.

A. General Information:

Social Security Number			Birth Date
Last Name	First Name	MI	Work Phone
Home Address			Home Phone
City	State	Zip	

B. Reason for coverage change New enrollee Moving out of service area Dropping or reducing coverage
 Qualifying change (Your reason for change must be due to one of the following events below. You must complete this form and return it within 30 days of the change.)

Check the qualifying change that applies:

- | | | |
|--|--|---|
| <input type="checkbox"/> Marriage | <input type="checkbox"/> Ineligible dependent became eligible ¹ | <input type="checkbox"/> Returning to work from unpaid leave of absence or maternity disability |
| <input type="checkbox"/> Divorce | <input type="checkbox"/> Spouse/dependent no longer eligible ¹ | <input type="checkbox"/> Significant change in employee's or spouse health care coverage (not cost) attributable to spouse's employment |
| <input type="checkbox"/> Legal Separation | <input type="checkbox"/> Taking unpaid leave of absence | <input type="checkbox"/> Spouse changing employment from part-time to full-time or full-time to part-time |
| <input type="checkbox"/> Birth of Child | <input type="checkbox"/> Termination of employment (Provide employer's phone number) | <input type="checkbox"/> Spouse's/domestic partner's employer conducts open enrollment & spouse/domestic partner changes elections |
| <input type="checkbox"/> Adoption | <input type="checkbox"/> Change in your employment or of your spouse/domestic partner | <input type="checkbox"/> You, your spouse or domestic partner, or dependent loses eligibility or becomes eligible to participate in a premium assistance program under Medicaid or Children's Health Insurance Program (CHIP) coverage ² |
| <input type="checkbox"/> Death of spouse/dependent | <input type="checkbox"/> Domestic partner relationship terminated | |
| <input type="checkbox"/> Changing place of residence to outside of the plan service area | <input type="checkbox"/> Domestic partner relationship declared (request declaration form) | |
| <input type="checkbox"/> Medicare eligibility | | |

¹ Please give details in comment section.

² Must notify the Employee Service Center within 60 days of loss of Medicaid/CHIP or of the eligibility determination. All other qualifying events must be communicated to the Employee Service Center within 30 days of the event.

Date of qualifying change:	Comments:
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C. Reduced Life Insurance (Applicable to CP&L retirees prior to 1/1/02 only)

Optional + Basic = Total

\$40,000 + \$10,000 = \$50,000* \$15,000 + \$10,000 = \$25,000* \$0 + \$10,000 = \$10,000

*These options are applicable only if these amounts are less than maximum amount available.

D. Other Medical Coverage – Complete only if:

❖ Your enrolled spouse/domestic partner or dependent children are covered under another employer sponsored medical, dental, or vision plan.

- Name and address of employer providing other coverage: _____
- Insurance carrier/plan name: _____
- Policy number: _____
- Effective date of coverage: _____

❖ Names and social security numbers (SSN) of enrolled spouse/domestic partner/children with other employer-sponsored medical coverage:

Name _____ SSN _____

Name _____ SSN _____

Over

E. Medical, Dental, and Vision

Medical	Requested			Dental	Requested		
	Self	Self+1	Family		Self	Self+1	Family
No Coverage	<input type="checkbox"/>			Dental			
AvMed HMO (Florida only)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	No coverage	<input type="checkbox"/>		
BCBS HDHP	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Premium	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
BCBS Standard	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Vision			
BCBS Choice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	No coverage	<input type="checkbox"/>		
BlueCare HMO (Florida only)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Basic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
UnitedHealthcare Standard	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Optional	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
UnitedHealthcare Choice Plus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				

Refer to the eligible dependent definition in the medical, dental or vision booklets to verify your dependent's eligibility. If you are dropping your spouse due to a legal separation or divorce, dropping your domestic partner due to termination of the relationship, or dropping a child who no longer meets the dependent definition due to marriage, age, ineligible student status, or because the child is no longer supported by you or your spouse, COBRA continued coverage may be available.

Medical	Vision	Dental	Relationship to you	BlueCare HMO and AvMed HMO: Primary Care Physician and/or OB/GYN Name (provide PCP# or ID #)
Add Delete	Add Delete	Add Delete		
<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	01 Employee Self	<input type="checkbox"/> New Patient
<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	02 Spouse/Domestic Partner (circle one) Gender: M F Date Medicare Coverage Effective: SSN _____ Birth Date _____ Home Address: _____ City _____ State _____ Zip _____ Date Medicare Coverage Effective: _____	<input type="checkbox"/> New Patient
<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	03 Child Name _____ Gender: M F SSN _____ Birth Date _____ Home Address _____ City _____ State _____ Zip _____	<input type="checkbox"/> New Patient

Attach sheet for additional dependents.

F. Healthcare reimbursement account (you will be billed monthly). If you stop participation, you can not re-enroll. Retirement Credit Eligible, and surviving dependents are not eligible.

Total amount to be contributed (for remainder of the year): \$ _____	Automatic claims reimbursement for dental. <input type="checkbox"/> Yes <input type="checkbox"/> No
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G. I acknowledge the above elections/declinations/changes of coverage and authorize Progress Energy to make any necessary deductions, if applicable. I understand that failure to make premium payments when due may result in termination of coverage. I understand that if I elect benefits for ineligible dependents as defined by the health benefit plans, I will be in violation of the Company's Code of Ethics. I may also be required to pay damages and costs to the Company, including any benefit payments made with respect to an ineligible dependent. I agree that my dependents and I will abide by the provisions of the Agreement for the Plan(s) in which I am enrolling and that any health care provider may furnish the claims administrator such information as may be required to process claims. All the information furnished by me is true and complete to the best of my knowledge.

Signature _____

Date _____

Return completed form to the Employee Service Center, PEB 16 ESC, P. O. Box 1551 Raleigh, NC 27602. If you have questions, call 800-546-5705 or email employee.service@pgnmail.com. Changes received in the Employee Service Center after the 15th of the month may not be reflected until the next pension payroll cycle. Retain a copy for your records.