2026 Fire Retiree Enrollment Form

HUMAN RESOURCES
DENVER PUBLIC SAFETY

If you are a new enrollee or making a benefit plan change, you must complete this benefits election form and submit within 30 days of the event. To protect your privacy, use our online SecureShare to send documents.
If you are adding a new dependent, documentation is required.

_____ Open Enrollment _____ New Enrollment _____ Waive/Cancel Coverage _____Change

Effective Date: *Medicare forms MUST be received and processed prior to the 1st of month*

Retiree Information (Please Print)

Last Name:	Middle:	First Name:	
Physical Address (No PO Boxes):			
City/State/Zip:		Date of Birth:	
Telephone Number:		Cell Number:	
Last 4 of Social Security Number:	XXX-XX-	Email Address:	

TO MAKE YOUR SELECTIONS, PLEASE CIRCLE THE DESIRED OPTION FOR EACH BENEFIT PLAN

Retiree Medical Options - Group #00074

Retiree Rates (UNDER 65 - Non Medicare)	Retiree Only	Retiree + Spouse	Retiree + Children	Retiree + Family
Kaiser HDHP	$607.00	$1,247.00	$1,215.00	$1,753.00
Kaiser HMO	$819.00	$1,673.00	$1,631.00	$2,357.00
Kaiser Choice PPO	$1,006.00	$2,058.00	$2,006.00	$2,894.00
Kaiser Out-of-Area	$1,006.00	$2,058.00	$2,006.00	$2,894.00
Waive non Medicare medical plans	$0.00			

Combined Rates = Medicare Sr. Adv* and Non Medicare with High Deductible Health Plan	Kaiser Senior Advantage Silver	Kaiser Senior Advantage Gold	
Subscriber Only = One on Medicare	$158.14	$222.78	
Subscriber + One Dependent =Two on Medicare	$316.28	$445.56	
Subscriber + One Dependent = One on Medicare One HDHP	$765.14	$829.78	
Subscriber + Two or more Dependents = One Medicare plus HDHP**	$1,247.67	$1,312.31	
Subscriber + Two or more Dependents =Two Medicare plus HDHP**	$923.28	$1,052.56	
Subscriber Only - Medicare Part B only	$723.31	$787.95	

Combined Rates = Medicare Sr. Adv* and Non Medicare with HMO	Kaiser Senior Advantage Silver	Kaiser Senior Advantage Gold	
Subscriber Only = One on Medicare	$158.14	$222.78	
Subscriber + One Dependent =Two on Medicare	$316.28	$445.56	
Subscriber + One Dependent = One on Medicare One HMO	$977.14	$1,041.78	
Subscriber + Two or more Dependents = One Medicare plus HMO**	$1,624.72	$1,689.36	
Subscriber + Two or more Dependents =Two Medicare plus HMO**	$1,135.28	$1,264.56	
Subscriber Only - Medicare Part B only	$723.31	$787.95	
Waive Medicare and Combined medical plans	$0.00		

You and/or your dependent must be enrolled in Medicare Part A and Part B. You MUST also complete the carrier's Medicare Sr. Advantage enrollment form, provide a copy of your Medicare card, and submit to OHR Safety Benefits

*** Rates may vary depending on the number of children covered on Medicare Sr. Advantage.*

Dental Options - Group #7984

Retiree Rates	Retiree Only	Retiree + 1 Dependent	Retiree + 2 or more Dependents
Delta Dental Medium	$22.92	$43.55	$62.87
Delta Dental High	$37.33	$70.93	$99.47
Delta Dental Premier	$47.17	$89.61	$125.66
Waive Dental	$0.00		

Vision Options - Group #866351

Retiree Rates	Retiree Only	Retiree + Spouse	Retiree + Children	Retiree + Family
Humana Vision	$12.13	$24.72	$25.17	$38.38
Waive Vision	$0.00			

Dependent information: please list below and provide supporting documentation along with this completed and signed form

Dependent Information - Please complete ALL boxes for each eligible dependent. Eligible dependents are: **SPOUSE, CHILD, STEPCHILD**. If a dependent is listed that does not meet this criteria, you may be responsible for reimbursing the insurance carrier for all claims. **PLEASE NOTE:** social security numbers for each dependent enrolled are required to comply with the Centers for Medicare and Medicaid Services (CMS) Medicare Secondary Payer program. If you are a surviving spouse, your new spouse is not an eligible dependent.

Dependent(s) Name	Medical	Dental	Vision	Relationship	Date of Birth	Social Security Number	Sex (Circle One)	
							M	F
							M	F
							M	F

Dependent Documentation

Spouse includes those as defined as common-law and same-sex legally married.
Legally separated or divorced spouses are not eligible for coverage.

Copy of marriage certificate, or Common Law Affidavit or State Civil Union documents. If you are a surviving spouse, your new spouse is not an eligible dependent.

AND *proof of dependency*

A copy of your most recent tax return (front page through line 6 of Form 1040 & signature page). Note: if your spouse files married separately, head of household or single, you will need to submit their Form 1040. Please black out the first five digits of the SSN#'s and financial information.

OR a copy of *TWO* of the following documents:

Proof of shared residence via joint mortgage statement or rental agreement
Automobile title or registration showing joint ownership of vehicle
Joint checking, bank, credit or investment account statement
A will and/or life insurance policy which designates the other as primary beneficiary

CHILD (Age 26 or under) who is:

An eligible child is your natural child, legally adopted, in the process of being adopted, or is subject of a Qualified Medical Support Order. Birth Certificate or Court Order is required.

STEPCHILD (Age 26 or under) children of former spouses, who do not meet one of the above requirements, are not eligible for coverage.

WHEN SPOUSE IS NOT enrolled in plan *AND* if child is related to you through marriage: (both documents required)

Birth Certificate or Court Order is required AND Spouse Dependency Documents Required.

You may mail completed forms to:
OHR Safety Benefits
201 West Colfax Ave, Dept 412
Denver, CO 80202

OR

You may email your completed enrollment form(s) to SafetyBenefits@denvergov.org. If you wish to submit your changes online to a secure email, send an email to SafetyBenefits@denvergov.org and a secure link will be sent to you to upload your documents. Please ensure that you keep a copies for your records. If you need assistance, please contact OHR Safety Benefits at 720-913-6741, option 1.

AUTHORIZATION:

All enrollees: I certify the above information to be correct to the best of my knowledge. I understand that it is my responsibility to report any change in the eligibility of my dependents; that the benefits and services of the elected plan are coordinated with those provided by any other group hospital or medical benefit or service plan; and that any controversy (including any claim for money damages) between any plan member or the member's heirs or personal representatives and such HMO (including its agents, staff physicians, employees and providers) is subject to binding arbitration instead of a court trial. By signing this enrollment form, I authorize the selected health benefit plan to use and access my medical records for claims processing, quality assurance and utilization of review purposes. This authorization will be valid for the duration of my enrollment in the selected health benefit plan.

Print Name: _____ **Signature:** _____ **Date:** ____/____/_____