Northwestern	2025 Retiree Open Enrollment Form	Submit completed form to: askhr@northwestern.edu or Northwestern Benefits Office 1800 Sherman Ave Evanston, IL 60201

1. INSTRUCTIONS

During Open Enrollment for 2025 coverage, if you and all covered dependents have not used tobacco-products within the past six (6) months, you must return this form with the tobacco use section updated, otherwise you will be assessed at $50 monthly surcharge. You may only use this Open Enrollment period to switch existing plans or drop plans. You may **not** use Open Enrollment to pick up coverage or add dependents.

To update the Tobacco Use status and/or change or drop medical and/or dental, complete this enrollment form and submit it to the Benefits Office by **Friday, November 8, 2024, at 5 p.m**. for changes to take effect January 1, 2025.

2. PERSONAL INFORMATION

Employee ID (on your NU Wildcard)	Social Security Number (if no Wildcard number available)

Employee Last Name	First Name	M.I.	❑ Male ❑ Female	❑ Former Faculty/Staff ❑ Spouse/Dependent

Home Street Address	Apt	City	State	Zip

Date of Birth	Home Phone	Email

3. NORTHWESTERN RETIREE ELECTIONS

Medical Coverage	Choose Your Health Plan	Dental Coverage	Choose Your Dental Plan	Legacy Vision Coverage
❑ Change ❑ Drop ❑ Continue ❑ Re-enroll Due to 2024 Waiver	❑ Legacy PPO (BCBS) ❑ Legacy HMO (BCBS) **Tobacco Use** (anyone covered) ❑ Yes ❑ No	❑ Change ❑ Drop ❑ Continue ❑ Re-enroll Due to 2024 Waiver	❑ Legacy HMO Guardian ❑ Legacy PPO (BCBS)	❑ Drop ❑ Continue ❑ Re-enroll Due to 2024 Waiver

4. ADD/DROP DEPENDENTS *Only complete the following section for dependents with enrollment changes.*

Last Name, First Name MI	❑ Male ❑ Female	Date of Birth	❑ Spouse/Partner ❑ Child	Social Security Number
Medical Coverage ❑ Change ❑ Drop ❑ Continue ❑ Re-enroll Due to 2024 Waiver	**Dental Coverage** ❑ Change ❑ Drop ❑ Continue ❑ Re-enroll Due to 2024 Waiver			**Vision Coverage** ❑ Drop ❑ Continue ❑ Re-enroll Due to 2024 Waiver

Last Name, First Name MI	❑ Male ❑ Female	Date of Birth	❑ Spouse/Partner ❑ Child	Social Security Number
Medical Coverage ❑ Change ❑ Drop ❑ Continue ❑ Re-enroll Due to 2024 Waiver	**Dental Coverage** ❑ Change ❑ Drop ❑ Continue ❑ Re-enroll Due to 2024 Waiver			**Vision Coverage** ❑ Drop ❑ Continue ❑ Re-enroll Due to 2024 Waiver

5. AUTHORIZATION

(1) I elect coverage under the above-selected Health Plan on behalf of myself and the above-listed dependents. (2) I certify that the above information is correct to the best of my knowledge and belief. (3) I hereby authorize any licensed physician, hospital, clinic, government agency or other health or medically-related facility, insurance company, organization or institution that has any records or knowledge of my health or the health of any member of my family to exchange such information with the above-selected health care provider--including, without limitations, information relating to mental illness or use of drugs or alcohol. I understand that the information will be used for the purpose of review, investigation, or evaluation of coverage claims for health insurance benefits provided to me and/or any of my dependents. (4) I agree to abide by the terms and conditions of the Plan Document and Certificates of Insurance. This authorization is valid for the term of coverage of the contract under which this Health Plan enrollment is effective. I am aware of my right to receive a copy of the authorization upon request and agree that a photographic copy of this authorization is as valid as the original.

SIGNATURE DATE