# Surviving Spouse/Dependent Election Form

_____ S.S.#_____
Retiree Name (please print)

_____ S.S.#_____
Surviving Spouse/Dependent Name (please print)

Please check one of the following boxes:

☐ I **accept** coverage.

Please choose the coverage desired:

☐ **Individual**:

| | | |
|---|---|---|
| | Medical | $ 849.01 per month |
| | Excess Medical | $ 3.57 per month |
| | Dental | $ 47.22 per month |

☐ **Family**:

| | | |
|---|---|---|
| | Medical | $ 1,926.21 per month |
| | Excess Medical | $ 7.65 per month |
| | Dental | $ 79.19 per month |

☐ **Medicare**:

| | | |
|---|---|---|
| | Individual | $ 452.79 per month |
| | Family w/1 Medicare | $ 1,530.00 per month |
| | Dental Individual | $ 47.22 per month |
| | Dental Family | $ 79.19 per month |

☐ I **decline** coverage:

Signature_____ Date_____

**FOR OFFICE USE ONLY**

Processed into ☐FM ☐NYBEAS_____ Date_____

Sent to Business Office_____ Date_____

Cc: LD
Updated 7/27/16