# *Staff Education Association Retirees VEBA*

## Insurance Enrollment Form

**Retiree Name:** _____

Address: _____

City: _____ State: _____ Zip Code: _____

Primary Contact Phone Number: _____ Email_____

Male ____ Female ____ Date of Birth: _____

Retirement Date: _____

Social Security Number: _____ *Medicare ID Number: _____

***A COPY OF YOUR MEDICARE CARD MUST BE RETURNED WITH THIS FORM**

**I choose to accept coverage: _____**

_____ _____

Retiree Signature Date

**Spouse/ Dependent Name**: _____

Male _____ Female _____ Date of Birth: _____

Social Security Number: _____ *****Medicare ID Number: _____

***A COPY OF THEIR MEDICARE CARD MUST BE RETURNED WITH THIS FORM**

**Retiree Spouse/Dependent chooses to accept coverage: _____**

_____ _____

Spouse/Dependent Signature Date

***** If you are not yet 65 you will need to supply this information to **SEARV** after you enroll in Medicare.