CITY OF WORCESTER
INTENTION TO RETIRE

EMPLOYEE INFORMATION:

Employee Name _____

Street Address _____

Mailing Address _____

City _____ State _____ Zip Code _____

Social Security Number _____ Date of Birth _____

Department _____ E-mail address _____

Date of Retirement _____ Home Phone # _____

Medicare Information:

Are you eligible? Y or N Are you enrolled? Y or N Number on Medicare Card: _____

Effective Date of Part A: _____ Effective Date of Part B: _____

SPOUSE INFORMATION:

Name of Spouse _____

Social Security Number of Spouse _____ Date of Birth _____

Medicare Information:

Are you eligible? Y or N Are you enrolled? Y or N Number on Medicare Card: _____

Effective Date of Part A: _____ Effective Date of Part B: _____

I wish to continue the following benefits as provided by the City of Worcester:
(Check all of the benefits that you now have, that you would like to continue carrying through your retirement.)

	YES	NO	N/A
Health Insurance (BCBS or FCHP)			
Dental Insurance (Altus)			
Vision Insurance (UHC)			
Basic Life (Unum)			
Optional Ins. (Unum)			
Universal Life (Trustmark)			

****You can continue your Basic Life and *Optional Life through your retirement, however if you are canceling your life insurance, please include a brief note of request and return with this form.**

_____ _____
Employee Signature Date

Please return completed form to:

City of Worcester Benefits Office
455 Main Street – Room 109
Worcester, MA 01608

*** Optional Life Insurance terminates at age 75.**

H:\worddocs\Schmickl\RETIREES\2013\INTENTION TO RETIRE FORM 2012.doc

Print Form