City of Detroit Police and Fire Retiree Healthcare Trust

Enrollment Form 2026

(Return this form to BeneSys at P.O. Box 1198, Troy, MI 48099-1198 or via email: enrollmentdocs@benesys.com by November 3, 2025)

☐ RETIREE ONLY	☐ RETIREE & SPOUSE	☐ RETIREE, SPOUSE & DEPENDENT	☐ SURVIVING SPOUSE

(* required information)

*Last name	*First name	*MI	*Social Security number

*Street address	*Apt no.	*City	*State	*ZIP code

Gender ☐ Male ☐ Female | *Date of birth (MM/DD/YYYY)

*Marital status ☐ Single ☐ Married ☐ Divorced ☐ Widowed

*Phone number	Email address

*Medicare number

Dependent Information: ***Complete this section ONLY if enrolling a spouse and/or dependents on the Priority Health Medicare Plan, HRA, Dental or Vision Plan**

Relationship to Retiree	Dependent Coverage Selection		SSN	Date of Birth (MM/DD/YYYY)	Sex	Medicare ID Number
	Medical	Last Name, First Name				
Spouse	☐					ID#
Child	☐					ID#
Child	☐					ID#

Coverage Selection: ***Select your medical, dental and vision plan - IF declining medical, dental or vision select decline**

Medicare Advantage Plan Options for Retirees on Medicare Only Plus a **$125/mo.** Medicare Part B Credit SELECT **ONE** MEDICAL PLAN		HRA Options Select HRA Category on Back of This Form		Dental Plan Options SELECT ONLY **ONE** DENTAL PLAN				Vision Plan	
☐	Retiree - Priority Health PPO	☐	Retiree - On Medicare but Opt Out of Priority Health	Delta Dental **LOW** Plan		Delta Dental **HIGH** Plan		Vision Service Plan (VSP)	
☐	Spouse - Priority Health PPO	☐	Spouse - On Medicare but Opt Out of Priority Health	☐	Retiree/ Surviving Spouse *$31.72/mo*	☐	Retiree/ Surviving Spouse *$39.27/mo*	☐	Retiree/Surviving Spouse *$11.50/mo*
☐	Retiree - Priority Health HMO	☐	Retiree- Non-Medicare and Select HRA	☐	Retiree + Spouse *$60.90/mo.*	☐	Retiree + Spouse *$76.16/mo.*	☐	Retiree + Spouse *$11.50/mo.*
☐	Spouse - Priority Health HMO	☐	Spouse - Non-Medicare and Select HRA	☐	Family *$100.78/mo.*	☐	Family *$133.73/mo.*	☐	Family *$11.50/mo.*
☐	**Decline/Waive Priority Health Coverage**	☐	**Decline/Waive HRA Coverage**	☐	**Decline/Waive Dental coverage**			☐	**Decline/Waive Vision Coverage**

P.O. Box 1198 ◆ Troy, MI 48099-1198
Phone 248·641·4932 ◆ Facsimile 248·636·4191 ◆ Toll Free 833·725·5336
https://www.ourbenefitoffice.com/DPFRHC/Benefits/

HRA Options: *Select HRA Category Below	
☐	**Non-Medicare Eligible (Pre-65) - Retiree/Spouse/Widow *($275.00/mo.)***
☐	**Medicare Eligible Opt-Out - Retiree/Spouse/Widow *($275.00/mo.)***
☐	****Non-Medicare Eligible with under $75,000 Household Income on Public Exchange - Retiree/Spouse/Widow *($325.00/mo.)***
☐	*****Over 65 Non-Medicare Eligible - Retiree/Spouse/Widow *($400.00mo.)***
☐	**Non-Medicare Eligible Duty Disabled - Retiree *($400/mo.)***

****Required documentation must be submitted to continue coverage or enroll in this coverage – without this documentation, you will either be removed from this HRA or your request to enroll will be denied.**
- 2024 Federal Tax Return Transcript filed with the IRS (Form 4506-T or 4506T-EZ). (See sample of page 11)
- 2024 1095-B indicating Individual Marketplace insurance purchased from the web-based Federal and/or State Insurance site set up under the Affordable Care Act.
(If you do not have the 1095-B you may submit a copy of your insurance bill for the coverage purchased from the Exchange. The bill must show the coverage period and covered person(s), along with proof of payment and statement showing it is insurance from the Exchange.)
*****Documentation Required: Copy of statement from Social Security Office stating you are not eligible for Medicare due to lack of work credits.**

Authorization: I have elected to enroll myself and my listed dependents in the above medical, dental and/or vision plans.

Signature: _____ Date: _____