



City of Detroit Police and Fire Retiree Healthcare Trust

Enrollment Form 2027

(Return this form to BeneSys at: P.O. Box 1198, Troy, MI 48099-1198 or via email: enrollmentdocs@benesys.com, by November 2, 2026)

☐	RETIREE ONLY	☐	RETIREE & SPOUSE	☐	RETIREE, SPOUSE & DEPENDENTS	☐	SURVIVING SPOUSE
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(* 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										
*Medicare Number				Phone Number			Email Address			

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	☐					
Child	☐					
Child	☐					

Medical Coverage Selection:

Select your Medical Plan - IF declining medical plan select decline

Medicare Advantage Plan Options for Retirees on Medicare Only Plus a \$175/mo. Medicare Part B Credit SELECT ONE MEDICAL PLAN		HRA Options Select HRA Category on Back of This Form	
☐	Retiree/Surviving Spouse - Priority Health PPO	☐	Retiree/Surviving Spouse - On Medicare but Opt Out of Priority Health
☐	Spouse - Priority Health PPO	☐	Spouse - On Medicare but Opt Out of Priority Health
☐	Retiree/Surviving Spouse - Priority Health HMO	☐	Retiree/Surviving Spouse - Non-Medicare and Select HRA
☐	Spouse - Priority Health HMO	☐	Spouse - Non-Medicare and Select HRA
☐	Decline/Waive Priority Health Coverage	☐	Decline/Waive HRA 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/>

Dental & Vision Coverage Selection: Select your dental and vision plan - IF declining dental and vision select decline

NEW Humana Dental Plan Option SELECT ONLY ONE DENTAL PLAN						NEW Humana Vision Plan	
Humana Dental Plan (Preventative Waived) \$1,000 Annual Max		Humana Dental Plan (Preventative Waived) \$1,500 Annual Max		Humana Dental Plan (Preventative Waived) \$2,500 Annual Max		Humana Vision Plan	
☐	Retiree/Surviving Spouse \$35.34/mo.	☐	Retiree/Surviving Spouse \$43.75/mo.	☐	Retiree/Surviving Spouse \$51.91/mo.	☐	Retiree/Surviving Spouse \$10.34/mo.
☐	Retiree + Spouse \$67.84/mo.	☐	Retiree + Spouse \$84.85/mo.	☐	Retiree + Spouse \$100.68/mo.	☐	Retiree + Spouse \$10.34/mo.
☐	Family \$112.28/mo.	☐	Family \$148.98/mo.	☐	Family \$176.71/mo.	☐	Family \$10.34/mo.
☐	Decline Dental Coverage					☐	Decline Vision Coverage

HRA Options: Select HRA Category Below

☐	Non-Medicare Eligible (Pre-65) - Retiree/Spouse/Surviving Spouse (\$325.00/mo.)
☐	Medicare Eligible Opt-Out - Retiree/Spouse/Surviving Spouse (\$325.00/mo.)
☐	** Non-Medicare Eligible with under \$75,000 Household Income on Public Exchange - Retiree/Spouse/Surviving Spouse (\$375.00/mo.)
☐	*** Over 65 Non-Medicare Eligible - Retiree/Spouse/Surviving Spouse (\$400.00/mo.)
☐	Non-Medicare Eligible Duty Disabled - Retiree (\$400.00/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.

2025 Federal Tax Return Transcript filed with the IRS (Form 4506-T or 4506T-EZ, see example on page 11).

2025 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 an 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: _____