County of Putnam
Retiree Medical Insurance
Plan Enrollment Form

TO ENROLL: Effective Date: _____

INFORMATION MUST BE AN EXACT MATCH TO MEDICARE ID CARD

Please print clearly in ink or type:

Retiree's Name: _____
First Middle Last

Street: _____

City, State, Zip: _____

Sex: Male ☐ Female ☐ Date of Birth: _____ Social Security #: _____

Medicare #: _____ Date of Retirement: _____
Please include a copy of your Medicare ID Card

☐ I elect to participate in the High medical/prescription drug plan.

☐ I elect to participate in the Low medical/prescription drug plan.

If Spouse's Enrollment Form, please list County of Putnam retiree's name:
_____

Retiree Signature:_____ Date: _____

Please be sure to date and sign this form answering all questions and return to.

Benistar
10 Tower Lane – First Floor
Avon, CT 06001
1-800-BENISTAR