DUTCHESS COUNTY GOVERNMENT
RISK MANAGEMENT

Retiree Health Insurance Selection Form

To be Completed by Employee:

Name:_____ **Age:**_____ **DOB:**_____

Retirement Date:_____ **Union:**_____ **Employer:**_____

Current Health Insurance Plan:_____ ○ Individual ○ Family

Plan Selected for Retirement:_____ ○ Individual ○ Family

Medicare Eligible? ○ Yes ○ No **Dependent Medicare Eligible?** ○ Yes ○ No

List the Name and Date of Birth of each Dependent that will be on your plan.

1. Dependent Name:_____ **Dependent DOB:**_____
2. Dependent Name:_____ **Dependent DOB:**_____
3. Dependent Name:_____ **Dependent DOB:**_____
4. Dependent Name:_____ **Dependent DOB:**_____

Signature:_____ **Date:**_____

Submit completed form to Riskmanagement@dutchessny.gov.
See Checklist to Enroll in Retiree Health Insurance for more information.

For Office Use Only:

Length of Service Upon Retirement:_____
LOS Confirmation by: _____

Date entered into Logos:_____
Entered by: _____

Date entered into NFP:_____
Entered by: _____

ACH Authorization Received & Uploaded by: _____

Updated 12/2/25