2027 Retiree Benefits Change Form

If you want to make any changes to your retiree benefits, effective January 1, 2027, please complete and return this form **on or before October 30, 2026.** **If you do not wish to make any changes, no action is required**.

Remember: If you elect to drop coverage or remove a dependent or spouse from any plan, you will not be permitted to re-enroll in future years.

Return this form to LCRA Benefits Team by one of the following methods:

Secure fax: 512-498-1685
Email: lcra.benefits@lcra.org
Mail: PO Box 220, L-121 Austin, TX 78767
(Envelope enclosed. Must be postmarked no later than **October 30, 2026**)

Section 1: Retiree Identification

Complete all fields below.

Full Name:	
LCRA ID or SSN (Last 4):	

Section 2: Benefit Elections

Check the applicable boxes. If no changes are being made to your current coverage, no form is required.

Medical Insurance

☐ Remove Spouse ☐ Remove Child(ren) ☐ Waive/Cancel Coverage for Retiree

Dental Insurance

☐ Remove Spouse ☐ Remove Child(ren) ☐ Waive/Cancel Coverage for Retiree

Vision Insurance

Select Option: ☐ Option A- Enhanced Plan ☐ Option B- Standard Plan

Changes: ☐ Remove Spouse ☐ Remove Child(ren) ☐ Waive/Cancel for Retiree

Legal Services Plan

Select Option: ☐ Option 1- Ultimate Advisor Plus ☐ Option 2- Ultimate Advisor

Changes: ☐ Remove Spouse ☐ Remove Child(ren) ☐ Waive/Cancel Retiree

Section 3: Dependent Action Details

Complete section 3, if removing specific dependent(s).

Name of Dependent	Relationship	Action	Plans Affected
		☐ Remove	
		☐ Remove	

Section 4: Contact Information Update

Has your personal information changed? Provide current details for future communications.

Mailing Address:	
City/State/Zip:	
Phone Number:	
Email Address:	

Section 5: Authorization and Signature

I certify that the selections above represent my intent for the 2027 plan year. I authorize any necessary billing adjustments associated with these changes. I understand by dropping this coverage or dependent(s) I will **not** have the opportunity to re-enroll in the plan(s) or add the dependent back in the future.

***NOTE**: As a reminder, you signed an authorization for electronic payment of benefits premiums with LCRA. Your signature indicates that you understand that an automatic payment will be deducted on the 5th calendar day of each month from your identified financial institution. Any future debits initiated by LCRA for your retiree insurance premiums that are refused for the reason of insufficient funds will result in automatic termination of LCRA benefit coverage. Once benefits have terminated, you will no longer be eligible for re-enrollment in LCRA's retiree benefits in the future.*

Retiree Signature: _____ Date**:** _____