Retiree Benefits Change Form

Please **drop** the below coverage from **my benefits** effective Jan. 1, 2024.

☐ *Medical* ☐ *Dental* ☐ *Vision* ☐ *Legal*

If you wish to continue the coverage, but **drop a dependent(s)**, please print the name of the dependent(s) you wish to **DROP** and the plan below.

Example: Jane Smith, drop from medical

_____

_____

_____

***NOTE**: 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.*

_____ _____

Print your name **Date**

For verification, please provide:

Employee ID number: _____

OR

the last 4 numbers of your SSN:

X	X	X	-	X	X	-				

Has your personal information changed? If so, please print your new information below.

Update address: _____

_____

_____

Phone number: _____

Email address: _____

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

Secure fax: 512-498-1685

Email to: lcra.benefits@lcra.org

Or mail in the enclosed return envelope

This form must be postmarked no later than Oct. 20, 2023, to make changes to your 2024 benefits.