ROCHESTER INSTITUTE OF TECHNOLOGY

2026 Medicare-Eligible Retiree Benefits Open Enrollment Vision Change Form

***** You do not need to return this form unless you are making changes. *****

If you would like to cancel or reduce your vision coverage level, please complete and **return this form to RIT Human Resources by Friday, November 28, 2025**.

NOTE: *Effective 1/1/2025, retirees cannot newly enroll in vision coverage or add family members. You can remove family members and cancel coverage.* ***If you remove a family member, they cannot be re-added at a later date. If you cancel coverage, you cannot re-enroll at a later date.***

Name: _____ **Date of Birth:** _____

VISION CARE PLAN

If you would like to make a change in your election, please check the appropriate box(es) below:

I ELECT TO ❑ reduce coverage level ❑ cancel *(you cannot re-enroll at a later date)*

- ❑ Individual ($9.64 per month)
- ❑ Two Person ($19.26 per month))
- ❑ Family ($31.01 per month)

FAMIILY MEMBER INFORMATION FOR DISENROLLMENT

If cancelling a family member, list only the name of the person you are cancelling.

First Name: _____ **Last Name:** _____

Disenroll From: ❑ Vision

Relationship: ❑ Spouse ❑ Domestic Partner ❑ Child ❑ Step-Child ❑ Domestic Partner's Child

First Name: _____ **Last Name:** _____

Disenroll From: ❑ Vision

Relationship: ❑ Spouse ❑ Domestic Partner ❑ Child ❑ Step-Child ❑ Domestic Partner's Child

SIGNATURE

I agree to pay RIT's billing administrator, Lifetime Benefit Solutions, the required premium contributions for the benefits I have from RIT. Unless stated otherwise, I understand that I cannot change my RIT benefit elections until the annual Open Enrollment, unless I have a change in family or employment status and I elect the change in writing within 31 days of the event date, and that the change elected is consistent with the event. If there is an increase in any premium contributions during a Plan Year, RIT may adjust the billing amount. I further understand that if I do not pay the required premium contributions, my coverage will be cancelled and I will only be able to re-enroll under the reinstatement procedures. I further understand that RIT reserves the right to change, audit, discontinue or terminate benefits at any time for any reason and that the insurance companies may from time to time change their policies. I affirm that the people I elect to cover are eligible and I understand that if I submit this form for a person who is not eligible that I will be in violation of RIT Policy, which may result in my permanent ineligibility for benefits.

_____ _____

Signature Date

Provide your email address and we will send you a confirmation: _____

Return form by Friday, November 28, 2025 as follows:

RIT Human Resources ◆ 8 Lomb Memorial Drive ◆ Rochester, NY 14623-5604