



CITY OF JACKSON - RETIREES

Page Two

4. ENROLLMENT OPTIONS KEY

Non Union Retirees = WLT 906

CBPPO \$5000 Ded'I/HRA plan + 3-year Blue Rx (Under 65/Non-MCR) Medicare Supplemental + Rx Stipend (Over Age 65/MCR Eligible)

IAFF Union Retirees = WLT 901

Simply Blue/HSA or CBPPO \$5000 Ded'I/HRA plan--Blue Rx (Under 65/Non-MCR) Medicare Supplemental + Scriptguide Rx (Over Age 65/MCR Eligible)

POLC Supervisory Union Retirees = WLT 902

CBPPO \$5000 Ded'I/HRA plan + Blue Rx (Under 65/Non-MCR) Medicare Supplemental + Rx Stipend (Over Age 65/MCR Eligible)

POLC Non-Supervisory Retirees = WLT 907

CBPPO \$5000 Ded'I/HRA plan + Blue Rx (Under 65/Non-MCR) Medicare Supplemental + Rx Stipend (Over Age 65/MCR Eligible)

MAPE Union Retirees = WLT 903

CBPPO \$5000 Ded'I/HRA plan + 3-year Blue Rx (Under 65/Non-MCR) Medicare Supplemental + Rx Stipend (Over Age 65/MCR Eligible)

Former City Manager = WLT 905

Medicare Supplemental + Scriptguide Rx

Jackson Housing Retirees = WLT 908 (Discontinued 7/1/2014)

CBPPO \$1000 Ded'I/HRA plan + 3-year Scriptguide Rx (Under 65/Non-MCR) Medicare Supplemental + Rx Stipend (Over Age 65/MCR Eligible)

\*Above Retiree Benefits do NOT apply to employees hired after July 1, 2012

SECTION 5 - PRIMARY CARE PROVIDER CHOICE (For Blue Care Network Advantage Enrollments ONLY)

Retiree \_\_\_\_\_ Spouse \_\_\_\_\_

I CERTIFY THAT ALL INFORMATION IS TRUE & CORRECT TO THE BEST OF MY KNOWLEDGE AND UNDERSTAND THAT FALSE OR DECEPTIVE STATEMENTS WILL BE CONSIDERED FALSIFICATION OF COMPANY RECORDS AND MAY BE GROUNDS FOR TERMINATION.

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
(Retiree's Signature) (Date)

WAIVER OF BENEFITS ONLY

Because the Plan is contributory and if I have refused the insurance, I understand that if I request coverage for myself and or my eligible dependents at a later date, I may be subject to special enrollment period restrictions.

I decline the following employee coverage available to me:

- Medical  Prescription Rx  I am insured under another policy, please indicate below:

Employer's Name: \_\_\_\_\_ Carrier's Name: \_\_\_\_\_

I decline the following coverage available to my  spouse  spouse & children  children only

- Medical  Prescription Rx  My dependents are insured under another policy or group plan, please indicate below:

Employer's Name: \_\_\_\_\_ Carrier's Name: \_\_\_\_\_

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
(Retiree's Signature) (Date)

TO BE COMPLETED BY PERSONNEL

Group/Dept No. \_\_\_\_\_ Hire Date \_\_\_\_\_ Coverage Effective Date \_\_\_\_\_

Job Title \_\_\_\_\_ Group/Division#: \_\_\_\_\_

- BCN Adv  Medicare Supplemental  CBPPO5000 (New Retirees)  SimplyBlue (IAFF Only)  Life/Ad&d (IAFF Only)  Rx\$  Waiver  CBPPO1000 (Grandfathered Retirees Only)  Trad'l PSG (Grandfathered Retirees Only)  Address Change  Dependent - Add or Delete  Beneficiary Change (IAFF)

MAPE & NON-UNION: 3 Year Rx Bridge = Start Date \_\_\_\_\_ - End Date \_\_\_\_\_

Coverage Termination Date \_\_\_\_\_

Other/Comments \_\_\_\_\_

Authorized Signature \_\_\_\_\_ Date \_\_\_\_\_