

**CITY OF JACKSON
GROUP BENEFIT PLAN ENROLLMENT / CHANGE FORM
IAFF**

CITY OF JACKSON-IAFF
Angela Arnold
161 W. Michigan Ave.
Jackson, Michigan 49201
Ph (517) 768-6465 – Fax (866) 522-9005

New Enrollment
 Change of Information

BCBS-CommBlue\$5000+Blue Rx
 ___ Med Only #007000992-0019 (3TZW)
 ___ Med +Dental #007000992-0019 (3V00)
 ___ Med + Vision #007000992-0019 (3TZT)
 ___ Med + D + V #007000992-0019 (3TZY)
 Freestanding Dental/Vision
 Blue Dental Only #007000992-0003 (016L)
 Blue Vision Only #007000992-0005 (00JF)
 Blue D & V Only #007000992-0004 (1CH5)

1. EMPLOYEE INFORMATION - (Please Print Clearly & Fill Out Completely)

S.S.#: _____ Group/Location #: 911-5-2

Employee Name (Last, First, MI) _____

Address _____ City _____

State _____ Zip _____ Birth date _____ Sex _____ Phone # _____

Marital Status Married - Date _____ Single Divorced – Date _____ Widowed - Date _____

Medicare Eligible – Yes No (If yes, attach copy of Medicare Card)

2. IF MARRIED / SPOUSE INFORMATION

Spouse's Name (Last, First, MI) _____

Birth date _____ Sex _____ S. S. # _____

Does Spouse reside with you? Yes No Is Spouse Employed? No Yes Full Time Part Time

Employer Name _____ Phone # _____

Address _____ State _____ Zip _____

Does Employer Offer: Medical Coverage Yes No RX Card Yes No Dental Coverage Yes No
 Vision Coverage Yes No Flex Account Yes No

Is coverage available for family members: Yes No Does spouse carry family coverage? Yes No Denied

Does spouse carry coverage for himself/herself? Yes No Denied

Carrier Name _____ Group # _____ Phone # _____

3. Dependent Information

Names of eligible family members (other than yourself) who by definition will be covered under your Plan.

Relation	Name, Last, First, M.I.	S.S.#	Birth Date	Sex	Living With You		Other Coverage		Full Time Student
					Yes	No	Yes	No	
Spouse									
Dep									
Dep									
Dep									
Dep									
Dep									
Dep									

Are any dependents eligible for coverage under any other plan? Yes No

Are any dependents eligible for Medicare Yes No - If yes, please attach copy of Medicare Care

Are any dependents adopted? Yes No – If yes, please indicate name and date of adoption.

Have you included stepchildren as dependents? Yes No – If yes, indicate names.

Do your stepchildren reside with you? Yes No – Are they dependent upon you for support and maintenance? Yes No

4. BASIC LIFE INSURANCE

For life insurance it is necessary to designate a primary beneficiary (P). It is also recommended that a secondary beneficiary (S) be selected in the case that the primary beneficiary may not survive you. A beneficiary may be a person, such as a spouse, parent or child, it could also be your estate or an institution. A secondary beneficiary would only receive benefits if all primary beneficiaries are deceased. Do not include yourself as a beneficiary.

P or S	NAME	RELATIONSHIP	S.S.#
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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.

_____ / ____ / ____
(Employee'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's available to me:

CBPPOS\$5000+Rx Blue Dental Blue VSP Life/AD&D Flex LTD

I am insured under another policy, please indicate below:

Employer's Name: _____

Carrier's Name: _____

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

CBPPOS\$5000+Rx Blue Dental Blue VSP Flex

My dependents are insured under another policy or group plan, please indicate below:

Employer's Name: _____

Carrier's Name: _____

_____ / ____ / ____
(Employee's Signature) (Date)

TO BE COMPLETED BY PERSONNEL

Group/Location No. 911-5-2 Hire Date _____ Coverage Effective Date _____

Job Title _____ Salary: _____

BCBS-CommBlue\$5000 (/NO Scriptguide Rx) = 911-5-2

Blue Dental Blue VSP Life/Ad&d Flex LTD
 Waiver Address Change Dependent - Add or Delete Beneficiary Change

New Group Code # _____ Coverage Termination Date: _____

Other/Comments _____

Authorized Signature _____ Date _____