

**CITY OF JACKSON  
GROUP BENEFIT PLAN ENROLLMENT / CHANGE FORM  
POLC/S**

CITY OF JACKSON-POLC/ S  
Angela Arnold  
161 W. Michigan Ave.  
Jackson, Michigan 49201  
Ph (517) 768-6465

New Enrollment       BCBS-Community Blue5000+Blue Rx  
 Change of Information             Med Only #007000992-0019 (1DXR)  
       Med +Dental #007000992-0019 (1DY1)  
       Med + Vision #007000992-0019 (1DXQ)  
       Med + D + V #007000992-0019 (1DXZ)

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

S.S.#: \_\_\_\_\_ Group/Location#: 913-11

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	

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 Card

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:

CommBlue-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

CommBlue-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. 913-11 Hire Date \_\_\_\_\_ Coverage Effective Date \_\_\_\_\_

Job Title \_\_\_\_\_ Salary: \_\_\_\_\_

Community BluePPO5000+Rx=913-11(NO Scriptguide)

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 \_\_\_\_\_