CITY OF JACKSON GROUP BENEFIT PLAN ENROLLMENT / CHANGE FORM RETIREES

CITY OF JACKSON—RETIREES		New Enroll			J nder A			
Gary Minix 161 W. Michigan Ave.	Ĺ	Change of]	Informati	on				55-900 + Script Rx
Jackson, Michigan 49201								06 + Script Rx 007 (IAFF Only)
Ph (517) 768-6461 – Fax (517) 768-5824)ver Ag	e 65 – N	Aedicar	e Eligible
								plement #67955-900 HMO#00102828-0006
4 77 777 0000					\Box C	ash Stir	end	HIVIO#00102828-0006
1. EMPLOYEE	INFOR	MATION - (Please Prin	t Clearl	y & Fill	Out Com	pletely	
S.S.#:	·		De	pt. #:			The state of the s	
Employee Name (Last, First, MI)								
Address								
StateZipBii								
Marital Status Married - Date								
Medicare Eligible – Yes 🔲 No 🔲 (If yes, attach								
		RIED / SPOU	ISF INFO)DMA	TION			
Spouse's Name (Last, First, MI)								
Birth date								
Does Spouse reside with you? Yes No								
Employer Name		·		P	hone#_	70 A A.		
Address				State				Zip
Does Employer Offer: Medical Coverage Vision Coverage		es No R	X Card ex Accour	Ye t	es 🔲 N	o Der	ıtal Cov	rerage Yes No
Is coverage available for family members:	Yes 🗌 No	Does spous	se carry fai	nily co	verage?	☐ Ye	s 🗌 N	o Denied
Does spouse carry coverage for himself/herself?		Yes □ No □			_			
Carrier Name	Group #				Phon	a #		
		Donou Jour I				C #		
Names of eligible family member		Dependent I an yourself) when the second in			ill be co	vered u	nder you	ur Plan.
	S.S.#	Birth Date	Sex	Livin	g With ou	Ot	her erage	Full Time Student
				Yes	No	Yes	No	

Are any dependents eligible for coverage under an Are any dependents eligible for Medicare Yes			No	03.4		~		
	C-1-1-1	 If yes, please ase indicate na 	me and da	py of M te of ad	option	Care		
lave you included stepchildren as dependents?	Yes [$\frac{1}{1}$ No – If yes,			option.			
Do your stepchildren reside with you? 🔲 Yes [□ No – A	re they depend	lent upon v	ou for	support	and mai	ntenanc	e? Yes No

4. BASIC LIFE INSURANCE

P or S	NAME	RELATIONSHIP S.S.	ries are deceased. Do not S.S.#						
SECTION 5 - PRIM	ARY CARE PROVIDER CE	HOICE (For Blue Care Network Enrollments ONLY)							
Employee		Spouse							
Child:		Child:							
Child:		Child:							
Child:		Child:							
	Employee's Signature)	Y BE GROUNDS FOR TERMINATION / /							
	employee's signature	(Date)	(Date)						
		BENEFITS ONLY							
Because the Plan is contributory and if lependents at a later date, I may be subj	I have refused the insurance, I will it is it is a little in the special enrollment period it.	nderstand that if I request coverage for myself and or my eligible restrictions	e						
	, p per tou ,	con tenons,							
decline the following employee co	waraga's available to me.								
	Life/AD&D	☐ I am insured under another policy, please indica Carrier's Name:	te belov						
Medical ScriptGuideRx Employer's Name: decline the following coverage's a	Life/AD&D	Carrier's Name:	te belov						
Medical ScriptGuideRx Employer's Name: decline the following coverage's a Medical ScriptGuideRx My dependents are insured und	Life/AD&D Life/AD&D Livailable to my	Carrier's Name: children only lan, please indicate below:							
decline the following coverage's a Medical ScriptGuideRx My dependents are insured und	Life/AD&D Life/AD&D spouse	Carrier's Name: children only							
Medical ScriptGuideRx Employer's Name: decline the following coverage's a Medical ScriptGuideRx My dependents are insured und Employer's Name:	Life/AD&D Life/AD&D Life/AD&D Life/AD&D Life/AD&D Life/AD&D	Carrier's Name: children only lan, please indicate below: Carrier's Name: / /							
_ Medical	Life/AD&D available to my spouse ler another policy or group pl apployee's Signature)	Carrier's Name: spouse & children							
Medical ScriptGuideRx Employer's Name: decline the following coverage's a Medical ScriptGuideRx My dependents are insured und Employer's Name: (En	Life/AD&D available to my spouse ler another policy or group pl aployee's Signature) TO BE COMPLET	Carrier's Name: spouse & children							
Medical ScriptGuideRx Employer's Name: decline the following coverage's a Medical ScriptGuideRx My dependents are insured und Employer's Name: (En	Life/AD&D available to my spouse ler another policy or group pl aployee's Signature) TO BE COMPLET Hire Date	Carrier's Name: spouse & children							
Medical ScriptGuideRx Employer's Name: decline the following coverage's a Medical ScriptGuideRx My dependents are insured und Employer's Name: (En	Life/AD&D available to my spouse ler another policy or group pl aployee's Signature) TO BE COMPLET Hire Date	Carrier's Name: spouse & children							
Medical	Life/AD&D available to my spouse ler another policy or group pl apployee's Signature) TO BE COMPLET Hire Date (HCE) Hire	Carrier's Name: Spouse & children							
Medical ScriptGuideRx ScriptGuideRx ScriptGuideRx decline the following coverage's a Medical ScriptGuideRx My dependents are insured und Comployer's Name: (En	Life/AD&D available to my spouse ler another policy or group pl apployee's Signature) TO BE COMPLET: Hire Date are Owner	Carrier's Name: Spouse & children							
Medical ScriptGuideRx ScriptGuideRx Medical ScriptGuideRx Medical ScriptGuideRx My dependents are insured und Comployer's Name: (En	Life/AD&D available to my spouse ler another policy or group pl apployee's Signature) TO BE COMPLET: Hire Date Are Owner (HCE) Hire and CBPPO CBPPO dent - Add or Delete Beneficia	Carrier's Name: spouse & children							