CITY OF JACKSON
GROUP BENEFIT PLAN ENROLLMENT / CHANGE FORM
RETIREES

CITY OF JACKSON—RETIREES
Gary Minix
161 W. Michigan Ave.
Jackson, Michigan 49201
Ph (517) 768-6461 – Fax (517) 768-5824

☐ **New Enrollment**
☐ **Change of Information**

☐ **Under Age 65**
- ☐ **Traditional #67955-900 + Script Rx**
- ☐ **CBPPO #67955-906 + Script Rx**
- ☐ **FlexBlue #67955-907 (IAFF Only)**

☐ **Over Age 65 – Medicare Eligible**
- ☐ **Traditional Supplement #67955-900**
- ☐ **BCN Advantage HMO#00102828-0006**
- ☐ **Cash Stipend**

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

S.S.#: _____ Dept. #: _____

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 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.#
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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

Employee	_____	Spouse	_____
Child:	_____	Child:	_____
Child:	_____	Child:	_____
Child:	_____	Child:	_____

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)**

WAVIER 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:
☐ Medical ☐ ScriptGuideRx ☐ Life/AD&D ☐ **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**
☐ Medical ☐ ScriptGuideRx
☐ **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/Dept No. _____ Hire Date _____ Coverage Effective Date _____

Job Title _____ Hours Worked Per Week _____

☐ Officer ☐ 5% Share Owner ☐ (HCE) Highly Compensated Employee
☐ BCN ☐ Blue Traditional ☐ CBPPO ☐ ScriptGuideRx ☐ Life/Ad&d ☐ Waiver
☐ Address Change ☐ Dependent - Add or Delete ☐ Beneficiary Change

☐ New Group Code # _____ ☐ Coverage Termination Date _____

☐ Other/Comments _____

Authorized Signature _____ Date _____