

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

TO BE COMPLETED BY CITY/JACKSON PERSONNEL DEPARTMENT

CITY OF JACKSON—RETIREES

**Doria LaPorte
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Jackson, Michigan 49201
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- New Enrollment
 Change of Information

Under Age 65

- CBPPO\$5000 #007000992-0024 + Blue Rx (All Segments)
 CBPPO\$5000 #007000992-0025- No Rx* (MAPE/NU Only)
 SimplyBlueHSA #007000992-0018 (IAFF Grandfathered Only)
 Traditional #007000992-0012 + Rx (Grandfathered Only)
 CBPPO\$1000 #007000992-0017+ Rx (Grandfathered Only)

(*Mape/NU= 3-Yr Rx Max or to MCR:

Start/End Date _____, _____)

- Non Union 906 IAFF 901 POLC-S 902 POLC-NS 907
 MAPE 903 Former City Mgr 905

Over Age 65 – Medicare Eligible

- Traditional Supplement #007000992-0012
 Medicare Advantage w/ Rx #67373-600
 BCN Advantage HMO #00102828-0006
 Cash Stipend { Rx; Medical & Rx }

1. RETIREE INFORMATION - (Please Print Clearly & Fill Out Completely & Sign on Page Two)

S.S.#: _____ Retiree Unit: NonUnion – Firefighter – Police Supervisor – Police NonSupervisor – MAPE
(Circle Unit you retired from)

RETIREE 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									

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

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4. ENROLLMENT OPTIONS KEY

Non Union Retirees = WLT 906

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

POLC Supervisory Union Retirees = WLT 902

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

POLC Non-Supervisory Retirees = WLT 907

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

MAPE Union Retirees = WLT 903

CBPPO \$5000 Ded'l/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 Advantage + Rx (Over Age 65/MCR Eligible)

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

CBPPO \$1000 Ded'l/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#: _____

- MCR Adv BCN Adv Medicare Supp'l 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 _____