CITY OF JACKSON
GROUP BENEFIT PLAN ENROLLMENT / CHANGE FORM
POLC/NS

CITY OF JACKSON-POLC/NS
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☐ **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#: 912-_____

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 # _____

Note: If the premium share of your full-time employed spouse costs more than $1800 (single) or $2400 (two/family) annually, the spouse is NOT required to enroll in their employer's plan and can be covered under your City/Jackson plan. If the spouse elects NOT to enroll in their own employer plan, they will NOT be covered by the City Jackson *unless* they have to pay more than these stated annual amounts and proof/documentation of such cost is attached to this enrollment form.

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

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. _____912-_____ Hire Date _____ Coverage Effective Date _____

Job Title _____ Salary: _____

☐ Community BluePPO5000+Rx=912-7 (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 _____