2023 RETIREE

Benefit Enrollment/Change Form
(Health, Dental and Vision)

SECTION 1: PARTICIPANT INFORMATION

NAME: ______________________ HOME TELEPHONE: ______________ E-MAIL ________________

STREET: ___________________________ CITY: ________________ STATE: ______ ZIP: ________

SECTION 2: SELECT THE APPROPRIATE PLAN(S):

☐ BCBS – PPO
☐ BCBS – HMO BLUE ADVANTAGE
☐ BCBS – HMO IL
☐ DELTA DENTAL
☐ VSP VISION

SECTION 3: SELECT THE APPROPRIATE COVERAGE LEVEL:

BCBS MEDICAL:	☐ SINGLE	☐ SINGLE + 1	☐ FAMILY	☐ NONE
DELTA DENTAL:	☐ SINGLE	☐ SINGLE + 1	☐ FAMILY	☐ NONE
VSP BASIC:	☐ SINGLE	☐ SINGLE + 1	☐ FAMILY	☐ NONE
VSP ENHANCED:	☐ SINGLE	☐ SINGLE + 1	☐ FAMILY	☐ NONE

SECTION 4: COMPLETE THE FOLLOWING:

PLEASE BE ADVISED, YOU ARE ONLY ELIGIBLE TO CARRY THE PLANS YOU ORIGINALLY HAD AT THE TIME OF YOUR RETIREMENT. THE 2023 OPEN ENROLLMENT PERIOD WILL BE THE LAST OPPORTUNITY RETIREES WILL BE ABLE TO ADD DEPENDENTS TO EXISTING PLANS. IF YOU ARE ADDING A DEPENDENT, PLEASE ATTACH MARRIAGE LICENSE/CIVIL UNION CERTIFICATE AND OR BIRTH CERTIFICATE(S).
MOVING FORWARD, ADDITIONS WILL NOT BE CONSIDERED.
HMO PARTICIPANTS ARE REQUIRED TO PROVIDE YOUR CHOICE OF HMO GROUP AND PRIMARY CARE PHYSICIAN.

PARTICIPANT NAME	DOB	SEX	SSN		
	____/____/____	☐ M ☐ F	____/____/____		
CHOOSE COVERAGE FOR THIS PARTCIPANT:		MEDICAL	DENTAL	VISION	
		☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	
PRIMARY CARE PHYSICIAN & GROUP NUMBER IF APPLICABLE:					

SPOUSE/CIVIL UNION NAME	DOB	SEX	SSN		
	____/____/____	☐ M ☐ F	____/____/____		
CHOOSE COVERAGE FOR THIS PARTCIPANT:		MEDICAL	DENTAL	VISION	
		☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	
PRIMARY CARE PHYSICIAN & GROUP NUMBER IF APPLICABLE:					

CHILD NAME	DOB	SEX	SSN		
	____/____/____	☐ M ☐ F	____/____/____		
CHOOSE COVERAGE FOR THIS PARTCIPANT:		MEDICAL	DENTAL	VISION	
		☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	
PRIMARY CARE PHYSICIAN & GROUP NUMBER IF APPLICABLE:					

I CERTIFY THAT THE INFORMATION CONTAINED IN THIS FORM IS TRUE AND CORRECT TO THE BEST OF MY ABILITY. I HEREBY APPLY FOR PARTICIPATION IN MY EMPLOYER'S INSURED BENEFIT PLAN(S) FOR THOSE BENEFITS FOR WHICH I AM ELIGIBLE UNDER THE TERMS AND CONDITIONS OF SAID PLAN AND ANY PRESENT OR FUTURE AMENDMENTS THERETO, AND SUBJECT TO ACCEPTANCE OF MY APPLICATION. I AUTHORIZE THE RELEASE TO AND USE BY THE CLAIMS PROCESSOR OF ANY MEDICAL INFORMATION NECESSARY TO ESTABLISH THE VALIDITY OF ANY CLAIM FOR BENEFITS FOR MYSELF OR ON BEHALF OF MY DEPENDENTS. A PHOTO OF THIS AUTHORIZATION SHALL BE AS VALID AS THE ORIGINAL.

______________________________________ ______________________

SIGNATURE **DATE**

FOR OFFICE USE ONLY:
EFFECTIVE DATE: __________ **SECTION #:** __________ **HR INITIALS/DATE:** __________