CITY OF JACKSON
GROUP BENEFIT PLAN ENROLLMENT / CHANGE FORM
NON-UNION

CITY OF JACKSON
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☐ **New Enrollment**
☐ **Change of Information**

☐ **BCBS-CommBlue$5000**+Blue Rx
___**Med Only #007000992-0019** (3TZW)
___**Med +Dental #007000992-0019** (3V00)
___**Med + Vision #007000992-0019** (3TZT)
___**Med + D + V #007000992-0019** (3TZY)

☐ **Freestanding Dental/Vision**
☐ **Blue Dental Only #007000992-0003** (016L)
☐ **Blue Vision Only #007000992-0005** (00JF)
☐ **Blue D & V Only #007000992-0004** (1CH5)

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

S.S.#: _____ Group/Location #: 910-9-___

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

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:

☐ CBPPO5000+Rx ☐ Blue Dental ☐ BlueVSP ☐ Flex ☐ Life/AD&D ☐ 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**

☐ CBPPO5000+Rx ☐ Blue Dental ☐ BlueVSP ☐ 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. _____910-9-__ _____ Hire Date _____ Coverage Effective Date _____

Job Title _____ Salary _____

☐ CBPPO5000-Non W/S=910-9-1 (NO Scriptguide) ☐ CBPPO5000-Water/Sewer=910-9-3 (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 _____