Retiree Health Plan Enrollment/Change Form

Enrollment/Change forms must be typed or printed neatly and to its entirety.
Partially completed forms will not be accepted or processed.

Benefits Office Use Only:

Code: DEDDate:

RETIREE or BENEFICIARY INFORMATION

SSN	Last Name	First Name	M.I.	Gender	Date of Birth (mm/dd/yyyy)
				☐ Male ☐ Female	

Mailing Address (Street)	City	State	Zip	Phone Number

Marital Status	E-Mail	Retiree ID #	Division
☐ Single ☐ Married			

HEALTH PLAN COVERAGE *(Medical, Dental, Prescription, & City Wellness Centers)*

Non-Medicare-Eligible Medical Plan Election – Blue Cross Blue Shield	Single	Family
☐ HMP (Health Management Plan) – Group 72354 ☐ Traditional PPO Plan – Group 72355	☐	☐

Medicare-Eligible Members	Single	Retiree + 1	Family w/ Child
☐ Amwins Group Benefits	☐	☐	☐

NATURE OF APPLICATION

☐ New Enrollment	☐ Waive/Cancel Contract	Change Contract	Add Dependent	Remove Dependent
		☐ Plan Change ☐ Coverage Change	☐ Add Spouse ☐ Add Child *(Retirees can only add dependents if already have Family coverage)*	☐ Remove Spouse ☐ Remove Child

Event Type	Effective Date
☐ Newly Eligible/Retired (Retirement Date: ________________) ☐ Open Enrollment ☐ Marriage ☐ Birth/Adoption ☐ Divorce ☐ Loss/Gain of Coverage ☐ Death	______________________

LIST ALL DEPENDENTS COVERED UNDER THIS CONTRACT AND PROVIDE SOCIAL SECURITY NUMBERS.

NOTE: Copies of dependent verification (marriage certificate, birth certificate, adoption/custody paperwork) must be submitted with this document for all dependents.

Relationship	Last Name	First Name	M.I.	Gender	Social Security No.	Date of Birth (mm/dd/yyyy)
SPOUSE				☐ MALE ☐ FEMALE		
CHILD 1				☐ MALE ☐ FEMALE		
CHILD 2				☐ MALE ☐ FEMALE		
CHILD 3				☐ MALE ☐ FEMALE		
CHILD 4				☐ MALE ☐ FEMALE		
CHILD 5				☐ MALE ☐ FEMALE		
CHILD 6				☐ MALE ☐ FEMALE		

☐ I wish to waive/cancel the City of Montgomery Group Health Plan benefits.

☐ I wish to enroll in the City of Montgomery Group Health Plan benefits for which I am eligible. My application is subject to the terms and conditions of the agreement between my Group (City of Montgomery) and applicable plan carriers. I name my Group as my Group Agent or Remitting Agent. I ask my Group to pay plan carriers directly and I give my Group the right to deduct my part of the premiums from my pay (if applicable).

Everything I say in this application is true. I give up all rights to service if I have not told the complete truth everywhere in this application. I understand that any misrepresentation is fraud and will be pursued to the fullest extent allowed by law including all compensatory and punitive damages as well as costs and attorney's fees.

I will cooperate with you if you need information about other health policies I have, including payments by them, I will give it to you. If you need information to help you subrogate (substitute for me or a family member) or be reimbursed, I will give it to you.

I acknowledge by my signature that I have read and understand the important information above.

Signature of Retiree or Beneficiary	Date Signed	Signature of Authorized Representative	Date Signed

Submit signed Enrollment/Change Form to the City of Montgomery Benefits Office.

Benefits Division: 103 N. Perry St., Montgomery, AL 36104 **Ph#:** 334-625-3692 **Fax#:** 334-625-2316 **E-mail:** benefits@montgomeryal.gov