| Internal Use only | Client Name: First Responders VEBA CCVB Health Plan Number: |
|---|---|

# Pre-65 Age 55-64 Enrollment Form

**Carriers:** Blue Cross Blue Shield of Michigan (BCBSM) - Medical, Prescription Drug, Dental and Blue Vision

**Retiree and Spouse, each have the ability to enroll in their own plans with/without different levels of coverage as a Single person enrolling in the plan if they desire**. If electing to enroll as 1 individual, each plan participant must complete separate forms and send in their checks along with their enrollment forms in separate envelopes and will each pay their individual admin fee.

**Please complete enrollment form in Ink and check the applicable boxes ( ☐) below**

## Section I: Tell us about the retiree (eligible member)

| | | | |
|---|---|---|---|
| | | | month day year |
| Last Name | First Name | M.I. | Date of Birth |
| Address | City | State | Zip code |
| Daytime telephone number | Social Security Number | | Sex (M or F) |
| Retirement Date | Email Address | | |
| ☐ Salary ☐ Hourly | Name of Union, if hourly: | | |

Please check the appropriate Box as a Single Retiree/Spouse ☐ Retiree& Spouse ☐ Retiree and Family ☐

## Section II: List Spouse and/or All Dependents That Are Enrolling – ***Relationship code S (Spouse) SS (Surviving Spouse) DP (Domestic Partner) C (Child by birth or adoption) D (Disabled child)

| Name (First, MI, Last) | Relationship Code*** | Sex | Date of Birth | Full-Time Student | SSN |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |

**If any family members enrolling in this plan are enrolled in Medicare please, complete the below information:**

Name _____ Medicare Number _____ Effective Date: _____

## Section III: Important Notes To Help You Correctly Select and Complete Your Coverage Election.

1) **You can find a complete listing of your rates on the included enrollment worksheet. Please review these rates before selecting your coverage.**
2) **When selecting your coverage please check each box that pertains to coverage you/dependents are electing. For example, if you are enrolling as a Spouse or Child only, you need to check the appropriate box.**
3) **All enrollees are eligible if the Retiree is qualified and can enroll as Standalone participants and must complete the Retiree box and the Dependents box**
4) **Family Coverage is coverage including three or more individuals.**
5) **Please review all information and sign and date where necessary.**

**If you are a Retiree and/or Spouse and/or Dependent enrolling in the plan as a Single for the best pricing, each family member must complete their own form & pay individually for their plan options.**

## Effective Date for Coverage: / / 2023

***You MUST write an Effective Date to start coverage***

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**Copper Plan: Bundled Medical and Prescription Drugs including Dental and Vision**

☐ Retiree ☐ Spouse ☐ Child ☐ Family

**Copper Plan: Standalone Medical and Prescription Drugs (No Dental or Vision Coverage)**

☐ Retiree ☐ Spouse ☐ Child ☐ Family

**Bronze Plan: Bundled Medical and Prescription Drugs including Dental and Vision**

☐ Retiree ☐ Spouse ☐ Child ☐ Family

**Bronze Plan: Standalone Medical and Prescription Drugs (No Dental or Vision Coverage)**

☐ Retiree ☐ Spouse ☐ Child ☐ Family

**Silver Plan: Bundled Medical and Prescription Drugs including Dental and Vision**

☐ Retiree ☐ Spouse ☐ Child ☐ Family

**Silver Plan: Standalone Medical and Prescription Drugs (No Dental or Vision Coverage)**

☐ Retiree ☐ Spouse ☐ Child ☐ Family

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**PLEASE READ THE FOLLOWING INFORMATION. THE INFORMATION ON THIS FORM AND THE FOLLOWING CONDITIONS ARE PART OF MY CONTRACT WITH BLUE CROSS BLUE SHEILD OF MICHIGAN (BCBSM).**

I am applying for coverage for myself and my family member identified on this application under my group's or association's contract with BCBSM. Coverage begins on the date determined by BCBSM. When BCBSM accepts my application, I and covered members of my family are bound by the terms on the policy and this application. I understand that the submission of false or misleading information or the omission of material information on this form may result in rejection of my enrollment or retroactive termination of my coverage.

**Proof of eligibility:** I agree to provide proof of my dependent's eligibility for coverage when requested by BCBSM.

**Authorization:** I appoint my group or association to handle all matters of coverage. It may forward deductions from my wages. I am responsible for giving notice to my group or association of changes in my status and/or my family's status that affect coverage, such as marriage, divorce, birth, Medicare entitlements, or death of someone covered under the policy. I authorize BCBSM and/or my Primary Care Physician to obtain the medical records relating to me and my enrolled family members necessary for the coordination of our medical care, administration of my coverage with BCBSM, and for other purposes necessary for BCBSM to fulfill its contractual and statutory obligations.

**Release of Information:** I acknowledge that BCBSM requires me to provide my Social Security Number. In applying for coverage, I and my enrolled family members agree to permit providers and others to release "protected health information" (as that term is used in the Health Insurance Portability and Accountability Act of 1996, as amended) to BCBSM for purposed of administering our coverage. Upon my request, BCBSM will tell me where the information was sent.

Retiree Signature: _____ Date: _____
(If Enrolling)

Spouse Signature: _____ Date: _____
(If Enrolling)

This enrollment form must be completed in its entirety before coverage can be issued. Any missing information will delay your enrollment in being processed. Coverage will be effective the first of the month upon receipt of the completed enrollment form.

**Please return your completed enrollment form and the two month's premium payment to: 1Life Benefits ~ 4853 Galaxy Pkwy. Suite K ~ Cleveland ~ OH ~ 44128**

**Please make your check payable to 1Life Benefits**