City of Lincoln Park Health Options July 1, 2016 – June 30, 2017
Non Medicare Eligible Retiree Coverage Enrollment Form
(This form is for Non-Medicare Eligible Members Only)

Retiree Information

Retiree name (first, last)				Social Security #
Mailing Address (Street)				
City	State	ZIP Code	Date of Birth	Phone Number

Coverage	Option	All plans include prescription drug coverage.
Simply Blue PPO 500	☐ elect	**By selecting an option below, I agree to pay the following monthly cost:** ☐ Single: $382.57 ☐ 2 Person: $928.14 ☐ Family: $1,172.69
Simply Blue PPO 1500	☐ elect	**By selecting an option below, I agree to pay the following monthly cost:** ☐ Single: $289.88 ☐ 2 Person: $705.71 ☐ Family: $894.65
BCN HMO	☐ elect	**By selecting an option below, I agree to pay the following monthly cost:** ☐ Single: $344.74 ☐ 2 Person: $837.35 ☐ Family: $1059.19
Opt Out	☐ elect	**I agree to opt out of the City's medical plans for this plan year and receive the following monthly payment based on my contract type. I understand that if I have a change in family status I must notify the City within 30 days and my opt out payment will be adjusted accordingly.** ☐ Single: $150 ☐ 2 Person: $350 ☐ Family: $425

Dependent Information (Complete **only** if you are electing benefits for your eligible spouse or children.)
This enrollment form is for Non-Medicare Eligible Members Only.

	Last Name	First Name	M/F	Date of Birth MM/DD/YYYY	Social Security #
Spouse				/ /	
Dep-1				/ /	
Dep-2				/ /	
Dep-3				/ /	
Dep-4				/ /	

Complete this section <u>only</u> if you have selected Blue Care Network (BCN) HMO. Physician Information can be found at www.bcbsm.com.

	PCP Last Name/First Name (Required)	Address	New Patient? (Yes/No)	Physician's National Provider ID#
Retiree				
Spouse				
Child #1				
Child #2				
Child #3				
Child #4				

Coverage Agreement (Read and Sign)

I understand these benefit levels are good for only July 1, 2016 – June 30, 2017. Benefit levels may be different after this period. I understand that during the open enrollment period, or if a qualifying event (i.e. death, divorce, birth etc.) should occur, I will have the opportunity to change my selection or enroll in coverage if previously opted out. I also understand that it is my responsibility to notify the City of a change in status (i.e. divorce, death, birth, etc.) within 30 days of the qualifying event. Failure to notify the City of a change in status will result in loss of all pay outs by the City.

Signature x _____ **Date signed** _____

Email Address: _____