



Group 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)
				<input type="checkbox"/> Male <input type="checkbox"/> Female	
Mailing Address (Street)		City	State	Zip	Phone Number
Marital Status	E-Mail	ID Number		Division	
<input type="checkbox"/> Single <input type="checkbox"/> Married					

GROUP HEALTH PLAN (Medical, Dental, Prescription, Mental Health, Substance Abuse, & CareHere Wellness Centers)

Medical Plan Election		Single	Family
<input type="checkbox"/> HMP (Health Management Plan) - Group 72354		<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Traditional PPO Plan - Group 72355 (w/o Medicare) or Group 49505 (w/ Medicare)			

COORDINATION OF BENEFITS – If you are covered by other health insurance, please give the following information. Attach proof to this document.

Name of Contract Holder	Name of Insurance Company	Contract Number	Group Number	Effective Date

NATURE OF APPLICATION

<input type="checkbox"/> New Contract	<input type="checkbox"/> Waive/Cancel Contract	Change Contract <input type="checkbox"/> Plan Change <input type="checkbox"/> Coverage Change	Add Dependent <input type="checkbox"/> Add Spouse <input type="checkbox"/> Add Child	Remove Dependent <input type="checkbox"/> Remove Spouse <input type="checkbox"/> Remove Child
Event Type			Date Event Occurred / Effective Date	
<input type="checkbox"/> Newly Eligible/Retired (Retirement Date: _____) <input type="checkbox"/> Open Enrollment			_____	
<input type="checkbox"/> Marriage <input type="checkbox"/> Birth/Adoption <input type="checkbox"/> Divorce <input type="checkbox"/> Loss/Gain of Coverage <input type="checkbox"/> 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 application for all dependents.

Last Name	First Name	M.I.	Relationship	Social Security No.	Date of Birth (mm/dd/yyyy)
			<input type="checkbox"/> HUSBAND <input type="checkbox"/> WIFE		
			<input type="checkbox"/> SON <input type="checkbox"/> DAUGHTER		
			<input type="checkbox"/> SON <input type="checkbox"/> DAUGHTER		
			<input type="checkbox"/> SON <input type="checkbox"/> DAUGHTER		
			<input type="checkbox"/> SON <input type="checkbox"/> DAUGHTER		
			<input type="checkbox"/> SON <input type="checkbox"/> DAUGHTER		
			<input type="checkbox"/> SON <input type="checkbox"/> DAUGHTER		
			<input type="checkbox"/> SON <input type="checkbox"/> DAUGHTER		

I am electing to waive/cancel the City of Montgomery Group Health Plan benefits.

I apply for the 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
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Submit signed Enrollment/Change Form to the City of Montgomery Benefits Division.

Benefits Division: 103 N. Perry St., Montgomery, AL 36104 Ph#: 334-625-3692 Fax#: 334-625-4410 E-mail: benefits@montgomeryal.gov