First Responders Enrollment Form

1. Name:

First Name *Middle Name* *Last Name*

Address

Street *City* *State*

2. Date of Birth:

MM *DD* *YY* Retirement Date:

Telephone Number *Email Address*

☐ Male ☐ Female

Gender

Effective Date:

MM *DD* *YY*

DOB of Eligible Enrollee

If Retired, Name of Company Retired From

MM *DD* *YY*

**If you are enrolling and not the Eligible Party, include Eligible Party's Name and Date of Birth* *Name of Eligible Enrollee*

☐ *Male* ☐ *Female* ☐ *S* ☐ *SS* ☐ *DP* ☐ *C* ☐ *D*

Relationship Codes – S (Spouse); SS (Surviving Spouse); DP (Domestic Partner); C (Child by Birth or Adoption); D (Disabled Child)

Please complete your information, sign and return.

Medical carriers offered: Blue Cross Blue Shield.

Members: Retiree, Spouse/Domestic Partner, Surviving Spouse or Dependent have the ability to enroll individually in coverage as a Single person if they desire.

*Select the Coverage for the individual(s) enrolling in the plan below under one (1) Enrollment form if you are a qualifying member and/or Spouse and/or Dependent enrolling in the plan as a Family. If two (2) people are enrolling in the plan, selecting enrollment as a single on two (2) forms (*offers better pricing*). The two family members are not required to have the same coverage if they enroll individually. Each family member must complete their own form and send payment individually for their plan options.

3. Type of Enrollment

☐ New Enrollment (Bundled Medical, RX, Dental & Vision or Selected Medical Pairings)

☐ Dental+/-Vision

☐ New Enrollment (NON-Bundled Plan(s))

4. Change of Status

☐ Address Change

☐ Add Dependent

☐ Terminate Coverage

Other _____

5. Enrollee Information

☐ Eligible Retiree

☐ Eligible Retiree and Family (3+)

☐ Dependent

☐ Eligible Retiree and Souse/Domestic Partner

☐ Spouse/Domestic Partner/Surviving Spouse

6. Plan Options - Blue Cross Blue Shield Plans

BUNDLED PLAN OPTIONS

BUNDLED Medical, RX, Vision & High Dental Plan

- ☐ New Enrollment COPPER Plan
- ☐ New Enrollment BRONZE Plan
- ☐ New Enrollment SILVER Plan
- ☐ New Enrollment GOLD Plan

- ☐ Terminate (COPPER Bundled High Dental Plan)
- ☐ Terminate (BRONZE Bundled High Dental Plan
- ☐ Terminate (SILVER Bundled High Dental Plan)
- ☐ Terminate (GOLD Bundled High Dental Plan

BUNDLED Medical, RX, Vision & Low Dental Plan

- ☐ New Enrollment COPPER Plan
- ☐ New Enrollment BRONZE Plan
- ☐ New Enrollment SILVER Plan
- ☐ New Enrollment GOLD Plan

- ☐ Terminate (COPPER Bundled Low Dental Plan)
- ☐ Terminate (BRONZE Bundled Low Dental Plan)
- ☐ Terminate (SILVER Bundled Low Dental Plan)
- ☐ Terminate (GOLD Bundled Low Dental Plan)

UNBUNDLED PLAN OPTIONS

Medical, Vision & High Dental

- ☐ New Enrollment COPPER Plan — ☐ Terminate
- ☐ New Enrollment BRONZE Plan — ☐ Terminate
- ☐ New Enrollment SILVER Plan — ☐ Terminate
- ☐ New Enrollment GOLD Plan — ☐ Terminate

Medical, Vision & Low Dental

- ☐ New Enrollment COPPER Plan — ☐ Terminate
- ☐ New Enrollment BRONZE Plan — ☐ Terminate
- ☐ New Enrollment SILVER Plan — ☐ Terminate
- ☐ New Enrollment GOLD Plan — ☐ Terminate

Medical & High Dental

- ☐ New Enrollment COPPER Plan — ☐ Terminate
- ☐ New Enrollment BRONZE Plan — ☐ Terminate
- ☐ New Enrollment SILVER Plan — ☐ Terminate

Medical & Low Dental

- ☐ New Enrollment COPPER Plan — ☐ Terminate
- ☐ New Enrollment BRONZE Plan — ☐ Terminate
- ☐ New Enrollment SILVER Plan — ☐ Terminate

Medical & Vision Only

- ☐ New Enrollment COPPER Plan — ☐ Terminate
- ☐ New Enrollment BRONZE Plan — ☐ Terminate
- ☐ New Enrollment SILVER Plan — ☐ Terminate

Medical ONLY

- ☐ New Enrollment COPPER Plan — ☐ Terminate
- ☐ New Enrollment BRONZE Plan — ☐ Terminate
- ☐ New Enrollment SILVER Plan — ☐ Terminate

Dental & Vision ONLY

- ☐ New Enrollment Vision Plan — ☐ Terminate Vision Plan
- ☐ New Enrollment HIGH DENTAL Plan — ☐ Terminate HIGH DENTAL Plan
- ☐ New Enrollment LOW DENTAL Plan — ☐ Terminate LOW DENTAL Plan

By signing below you are also agreeing to the Terms and Conditions.

7. Signature _____ Date of Signature _____ (*MM* / *DD* / *YY*)

❒ Terms & Conditions

Please Read the following information. The information on this form and the following conditions are part of my contract with Blue Cross® Blue Shield® of Michigan. I am applying for coverage for myself and/or my family member identified on this application under my group's or association's contract with Blue Cross Coverage begins on the date determined by Blue Cross. When the carrier(s) accept(s) 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 Blue Cross Blue Shield of Michigan.

Authorization: I appoint my group or association to handle all matters of coverage. I am responsible for giving notice to Blue Cross® Blue Shield® of Michigan 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 Blue Cross and/or my Primary Care Physician to obtain the medical records relating to me and my enrolled family members necessary for the coordination of mine/our medical care, administration of my coverage with Blue Cross, and for other purposes necessary for Blue Cross to fulfill its contractual and statutory obligations.

Release of Information: I acknowledge that Blue Cross requires me to provide my Social Security Number. In applying for coverage, I and/or 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 Blue Cross for purpose of administering our coverage.

Instructions for Completion and Submittal of ALL Forms

Complete form by printing a blank form and filling in all necessary information.

Contact SHN with any question 1(888)338-7677

Completed forms can be faxed or emailed to SHN at: aszap@shninc.org
Or if faxing send to: 1-(216)831-4843

If mailing send to: SHN (Solidarity Health Network)
4853 Galaxy Parkway, Suite K
Cleveland, OH 44128

Blue Cross Blue Shield – Medical & RX Plan Options

Pre 65 / 2024 Rates

COPPER Plan	Medical and RX only
Single	$978.60
Two Person	$2,250.64
Family	$2,795.81

BRONZE Plan	Medical and RX only
Single	$1,199.32
Two Person	$2,780.37
Family	$3,457.97

SILVER Plan	Medical and RX only
Single	$1,535.57
Two Person	$3,584.97
Family	$4,463.70

GOLD Plan	Medical and RX only
Single	$1,725.31
Two Person	$4,042.73
Family	$5,035.92

The rates above include the administration fee

Blue Cross Blue Shield – Low Plan Dental / Vision
(Standalone no Medical) 2024 Rates

LOW PLAN		
	Dental /Vision	Dental Only
Single	$71.48	$62.59
Two Person	$138.71	$120.93
Family	$237.95	$208.44

An administration fee of $4.25 is included above

Blue Cross Blue Shield - High Plan Dental / Vision
(When adding to a medical plan) 2024 Rates

LOW PLAN		
	Dental /Vision	Dental Only
Single	$67.23	$58.34
Two Person	$134.46	$116.68
Family	$233.70	$204.19

No admin fee when adding Dental to a Medical Plan.

HIGH PLAN		
	Dental /Vision	Dental Only
Single	$74.55	$65.66
Two Person	$149.10	$131.32
Family	$259.33	$229.82

No admin fee when adding Dental to a Medical Plan.

Blue Cross Blue Shield – Medical Plan Options

Pre 65 / 2024 Rates

COPPER Plan	Medical and RX only	Medical, RX and Dental	Medical, RX, Dental and Vision
Single	$978.60	$1,036.94	$1,045.83
Two Person	$2,530.64	$2,367.32	$2,385.10
Family	$2,975.81	$3,000.00	$3,029.51

BRONZE Plan	Medical and RX only	Medical, RX and Dental	Medical, RX, Dental and Vision
Single	$1,199.32	$1,257.66	$1,266.55
Two Person	$2,780.37	$2,877.05	$2,914.83
Family	$3,457.97	$3,662.16	$3,691.67

SILVER Plan	Medical and RX only	Medical, RX and Dental	Medical, RX, Dental and Vision
Single	$1,535.57	$1,592.91	$1,601.80
Two Person	$3,584.97	$3,701.65	$3,719.43
Family	$4,463.70	$4,667.89	$4,697.40

GOLD Plan	Medical and RX only	Medical, RX and Dental	Medical, RX, Dental and Vision
Single	$1,725.31	$1,793.65	$1,792.54
Two Person	$4,042.73	$4,159.41	$4,177.19
Family	$5,035.92	$5,240.11	$5,269.62

The rates above include the administration fee