First Responders Enrollment Form

1. Name:

First Name | Middle Name | Last Name

Address

Street | City | State

2. Date of Birth:

MM | DD | YY

Telephone Number | Email Address

☐ Male | Female

Gender

Effective Date:

MM | DD | YY

DOB of Eligible Retiree

MM | DD | YY

Name of Eligible Retiree

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

☐ 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)

This is an electronic fillable form. Please complete by typing in your information and signing electronically or print, complete and sign.

Carrier: Blue Cross Blue Shield – Medical, Prescription Drug, Dental and Blue Vision. Spouse/Domestic Partner, Two Person or Dependent have the ability to enroll individually in any plan level of 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.

Pre-65 participants in stand alone Dental +/- Vision plans must complete this form to enroll or make changes to existing coverage.

3. Type of Enrollment

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

☐ Dental+/-Vision

4. Change of Status

☐ Address Change

☐ Terminate Coverage

☐ Add Dependent

☐ Other ____

5. Enrollee Information

☐ Eligible Retiree

☐ Eligible Retiree and Souse/Domestic Partner

☐ Eligible Retiree and Family (3+)

☐ Spouse/Domestic Partner

☐ Dependent

6. Plan Option

Gold (Bundled – Medical, RX, Dental and Vision)

☐ New Enrollment BUNDLED PLAN (Bundled Medical, RX, LOW Dental & Vision)
☐ New Enrollment BUNDLED PLAN (Bundled Medical, RX, HIGH Dental & Vision)
☐ Terminate (Bundled Medical, RX, LOW Dental & Vision)
☐ Terminate (Bundled Medical, RX, HIGH Dental & Vision)

Silver

☐ New Enrollment BUNDLED PLAN (Bundled Medical, RX, LOW Dental & Vision)
☐ New Enrollment BUNDLED PLAN (Bundled Medical, RX, HIGH Dental & Vision)
☐ New Enrollment (Medical, RX, LOW Dental)
☐ New Enrollment (Bundled Medical, RX, HIGH Dental)
☐ New Enrollment (Medical, RX and Vision)
☐ New Enrollment (Medical Only)
☐ Terminate (Bundled Medical, RX, LOW Dental & Vision)
☐ Terminate (Bundled Medical, RX, HIGH Dental & Vision)
☐ New Enrollment (Medical, RX, LOW Dental)
☐ New Enrollment (Bundled Medical, RX, HIGH Dental)
☐ New Enrollment (Medical, RX and Vision)
☐ New Enrollment (Medical Only)

Bronze

☐ New Enrollment BUNDLED PLAN (Bundled Medical, RX, LOW Dental & Vision)
☐ New Enrollment BUNDLED PLAN (Bundled Medical, RX, HIGH Dental & Vision)
☐ New Enrollment (Medical, RX, LOW Dental)
☐ New Enrollment (Bundled Medical, RX, HIGH Dental)
☐ New Enrollment (Medical, RX and Vision)
☐ New Enrollment (Medical Only)
☐ Terminate (Bundled Medical, RX, LOW Dental & Vision)
☐ Terminate (Bundled Medical, RX, HIGH Dental & Vision)
☐ Terminate (Medical, RX, LOW Dental)
☐ Terminate (Bundled Medical, RX, HIGH Dental)
☐ Terminate (Medical, RX and Vision)
☐ Terminate (Medical Only)

Copper

☐ New Enrollment BUNDLED PLAN (Bundled Medical, RX, LOW Dental & Vision)
☐ New Enrollment BUNDLED PLAN (Bundled Medical, RX, HIGH Dental & Vision)
☐ New Enrollment (Medical, RX, LOW Dental)
☐ New Enrollment (Bundled Medical, RX, HIGH Dental)
☐ New Enrollment (Medical, RX and Vision)
☐ New Enrollment (Medical Only)
☐ Terminate (Bundled Medical, RX, LOW Dental & Vision)
☐ Terminate (Bundled Medical, RX, HIGH Dental & Vision)
☐ Terminate (Medical, RX, LOW Dental)
☐ Terminate (Bundled Medical, RX, HIGH Dental)
☐ Terminate (Medical, RX and Vision)
☐ Terminate (Medical Only)

By signing below you are also agreeing to the Terms and Conditions on Page 3.

7. Signature ____________ Date of Signature ______ MM / ______ / ______ 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 Blue Cross 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 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 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 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. Upon my request, Blue Cross will tell me where the information was sent.

Instructions for Completion and Submittal of ALL Forms

Complete form by either (a) printing a blank form and filling in all necessary information in ink or (b) open the form and complete electronically (you are able to sign your form electronically or by printing). Don't forget to save your form on your computer once you have completed.

Contact Benistar with any question 1-800-236-4782

Completed forms can be faxed or emailed to
Benistar at: memelig@benistar.com
Or if faxing send to: 1-860-408-7025

If mailing send to:
Benistar Service Center
10 Tower Lane, Suite 100
Avon, Ct. 06001