Medical Enrollment Form
Retirees

Office Use Only:

Group number: 004007822 Section code:

SECTION 1: EMPLOYEE INFORMATION

Last name	First name	Social Security no. (required)

Date of birth (MM/DD/YYYY)	Phone no.	Email address	BSU ID no.	Effective date (MM/DD/YYYY)

Street address	City	State	ZIP code

SECTION 2: COVERAGE LEVEL

Select coverage level and tier below by checking the appropriate box below, **or** waive medical coverage.

Reason for application

☐ New retiree ☐ Annual open enrollment ☐ Surviving spouse/Dependent ☐ Waiver

Cancel coverage (Complete page 2)

☐ Myself* ☐ Spouse* ☐ Child(ren)* ☐ Other dependents*

* Include supporting documentation.

Type of coverage plan

☐ Retiree 65+ ☐ Spouse 65+ (001) ☐ Retiree Under 65 – High-Deductible Wellness PPO (003)

Enroll (Complete page 2)

☐ Myself ☐ Spouse ☐ Child(ren) ☐ Other dependents

Must be designated as a dependent on your federal income tax return to qualify for coverage.

SECTION 3: ADDITIONAL INFORMATION

Do you or any other of your dependents have other coverage? ☐ Yes ☐ No		Are you or any listed dependents presently enrolled in Medicare? ☐ Yes ☐ No		
Policyholder name	Policy/certificate no.	If enrolled in → Medicare provide:	Part A (Hospital) effective date	Part B (Medical) effective date

Name of person(s) covered	Social Security no.	Coverage effective date	Coverage termination date

Employer name	Carrier name

Carrier address	City	State	ZIP code

SECTION 4: AUTHORIZATION

Note: If a court decree requires you to cover your dependent under this plan, SUBMIT that portion of the court decree with this enrollment form. Please note that Social Security numbers are required on all covered dependents. THIS IS A REQUIREMENT UNDER FEDERAL LAW.

I hereby request coverage under the Group Policy offered by my Employer. I am an eligible Retiree/Retiree's spouse/dependent. I hereby authorize hospitals, physicians, or other providers of service to furnish to Anthem Blue Cross and Blue Shield, or its agents, upon request, any and all reports, records or copies thereof concerning any illness, injury or condition for which service was provided to me or my dependents together with like reports, records or copies thereof for all earlier services.

I understand if I do not enroll in the Employer-Sponsored Retiree program at the time of my retirement, I will not be able to enroll at a future date.

Employee signature	Print name	Date (MM/DD/YYYY)
Employer signature	Print name	Date (MM/DD/YYYY)

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SECTION 5: DEPENDENT INFORMATION

Is dependent's address different than employee's address? If "Yes", please provide full address below.

☐ Enroll ☐ Waive ☐ Cancel	Last name			First name		Middle initial	Date of birth (MM/DD/YYYY)	
	Street address			City			State	ZIP code
	Sex ☐ M ☐ F	Social Security no.	☐ Spouse ☐ Child ☐ Disabled ☐ Court ordered	**OR**	☐ Dependent who is designated as a dependent on my federal tax return			
☐ Enroll ☐ Waive ☐ Cancel	Last name			First name		Middle initial	Date of birth (MM/DD/YYYY)	
	Street address			City			State	ZIP code
	Sex ☐ M ☐ F	Social Security no.	☐ Spouse ☐ Child ☐ Disabled ☐ Court ordered	**OR**	☐ Dependent who is designated as a dependent on my federal tax return			
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	Sex ☐ M ☐ F	Social Security no.	☐ Spouse ☐ Child ☐ Disabled ☐ Court ordered	**OR**	☐ Dependent who is designated as a dependent on my federal tax return			
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	Sex ☐ M ☐ F	Social Security no.	☐ Spouse ☐ Child ☐ Disabled ☐ Court ordered	**OR**	☐ Dependent who is designated as a dependent on my federal tax return			
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	Street address			City			State	ZIP code
	Sex ☐ M ☐ F	Social Security no.	☐ Spouse ☐ Child ☐ Disabled ☐ Court ordered	**OR**	☐ Dependent who is designated as a dependent on my federal tax return			
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