Fermilab

Fermi Research Alliance (FRA)
Retiree Medical Plan Enrollment Change Form

Fermi ID	Social Security Number Not Needed	Retiree Last Name	Retiree First Name	Middle Initial

Street Address	City	State, Zip	Home/Cell Phone

Medical Coverage Change

Effective Date of Change:

☐ Plan Change to:

☐ Blue Cross Blue Shield PPO

☐ Blue Cross Blue Shield Blue Advantage HMO

☐ Coverage Change to:*

☐ Retiree and Spouse*

☐ Retiree and Child*

☐ Retiree Only*

Benefit Program ___**RET**____ Billing Effective Date _____ Payment Method __ACH_____

Please provide information below for yourself and your eligible dependents to be covered under the Fermilab Retiree Medical Plan

Name, Last/First/Middle Initial	Gender	Birth Date (mm/dd/yyyy)	Social Security Number Not Needed		Blue Cross - HMO Medical Group Number (3 digits)
Self			Not Needed		
*Spouse**			Not Needed		
*Child **			Not Needed		

**Please Note:* *Retirees can only enroll new dependents within 31 days of retirement, marriage or birth/adoption of a child. Retirees can cancel dependents but the dependents may not re-enroll in the plan at a later date.*

☐ **Cancel Coverage** ****I understand that I cannot elect coverage at a later date.**

I understand that premiums for my medical/dental coverage will be automatically deducted from my bank account. Completion of a bank authorization agreement is required. I understand that my coverage will be terminated for non-payment of my premiums. I understand that my coverage once terminated cannot be reinstated. FRA reserves the right to amend, modify or terminate the plan at any time.

Signature _____ Date _____

Benefits Office Signature _____ Date _____

Return the form to: Fermilab Benefits at benefitsoffice@fnal.gov
or mail to
HR - Benefits Office
PO Box 500, MS 126
Kirk Road & Pine St
Batavia, Illinois 60510