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Retirement Application and Medical Enrollment Form	BEN-RETAP-001	07/09/2010	005	10/5/2015

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Fermilab

Fermi Research Alliance (FRA)
2016 Retiree Medical Plan Enrollment Form

Fermi ID	Social Security Number	Employee Last Name	Employee First Name	Middle Initial

Street Address	City	State, Zip	Home Phone

2016 Medical Coverage

Effective Date of Change (*must be the first of the following month*):

☐ Plan Change ☐ Coverage Change*

☐ Blue Cross Blue Shield PPO ☐ Retiree and Spouse

☐ Blue Cross Blue Shield Blue Advantage HMO ☐ Retiree and Child

☐ Retiree Only*

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

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	Blue Cross - HMO PCP Name	Blue Cross - HMO Medical Group Number 3 digits
Self					
*Spouse**					
*Child **					

**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 coverage will be automatically deducted from my bank account. Completion of an 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
PO Box 500 MS 126 or via fax (630) 840-5207
Batavia, IL 60510