PPO Enrollment Form

BlueCross® BlueShield®

Applicant Information *(separate form must be completed for each individual to be covered)*

Name: (Last)_____ (First)_____ (MI)_____

Date of Birth:___/___/___ **Social Security Number:**_____-_____-_____

Street Address : _____

City : _____ **State:** **Zip:** _____

Home Phone: (____)_____

Retiree's Member Employer :_____

(check one): ____Male ____Female

(check one): G.M.P. Retiree _____ Spouse of Retiree _____ Surviving Spouse of Retiree _____

If you checked "Spouse of Retiree" or "Surviving Spouse of Retiree" complete the section at right:

Retiree's Name:

(Last)_____ (First)_____

Retiree's Social Security #: _____-_____-_____

Retiree's Employer : _____

PPO Option Selection: (Please see Plan option sheet for benefit details and monthly premiums)

___ Option 1: PPO Coverage w/Lower Prescription Deductible (higher monthly premium)

___ Option 2: PPO Coverage

_____

Acceptance/Authorization

Please sign the following:

I hereby enroll in the G.M.P.-Employers Retiree Trust PPO Option. I understand that I will be billed quarterly for the PPO premiums.

Retiree's Signature _____ Date _____

Use the pre-addressed envelope to return this form to:

G.M.P.-Employers Retiree Trust
5245 Big Pine Way SE
Ft. Myers, FL 33907-5998
Phone: 239-936-6242

Effective Date (to be completed by the Trust): _____
Month / Year

(Note: All coverage is effective on the first day of the month. Once this form has been received by the Trust, you will be enrolled in the PPO Option by the earliest possible date.)

IMPORTANT NOTE: IF YOU ARE ELIGIBLE FOR MEDICARE, YOU ARE **NOT** ELIGIBLE FOR PPO COVERAGE.