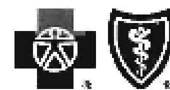

BlueCross®
BlueShield®

PPO Enrollment Form

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)

___ PPO Plus Coverage w/Lower Prescription Deductible (higher monthly premium)

___ 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.