Preferred Blue
A Highmark Blue Cross Blue Shield
Preferred Provider Program

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**: _____-_____- _____

Address:

Street _____

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 Member Employer: _____

Please check one if applicable (If additional space is required, attach a separate sheet).
If you___, or your spouse___, are enrolled in another Program or Medicare, please give the following information:
Name of Employer (if applicable):_____**Group No.**_____
Name of Insurance Carrier: _____**Effective Date:**_____
Name of Insured:_____**Is Coverage Still in Effect?**___**Yes**___**No**
Identification Number_____ **Insurance Carrier Phone#:** (__)_____

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.