LEXINGTON

RETIREE BENEFITS ENROLLMENT FORM | **EMPLOYEE #**

Employee Name (please print): ____
(Last name) (First name) (Middle Initial)

Current Address:____

City: ____________________ State: ____________Zip Code: ____________Apt. #________

Phone: ______________ Email: __________________ DOB:__________GENDER: M___ F___

CHECK THE TYPE OF PLAN AND COVERAGE LEVEL				
Coverage	**Single**	**Retire + Spouse**	**Retiree + Child(ren)**	**Family**
Anthem PPO – 1				
Anthem PPO - 2				
Anthem HSA - 1				
Anthem HSA - 2				
HSA Contribution $__________				
Medicare Advantage				
Delta Dental Option 1				
Delta Dental Option 2				
EyeMed Base Vision				
EyeMed Enhanced Vision				

PLEASE LIST ALL MEMBERS YOU WANT COVERED				
Name	**Relationship**	**Social Security**	**Date of Birth**	**Gender**

______________________________ ______________________
Employee Signature Date