

BMR Prescription Benefit Plan

Member enrollment form

EMPLOYER NAME

Plainfield Board of Education

PLAN/DIVISION CODE

New Add Change Effective Date	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
	m	m	d	d	y	y	y	y	y
Termination Effective Date	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
	m	m	d	d	y	y	y	y	y

Type of Request

☐ Add ☐ Change
☐ Terminate ☐ New Card

Type of Change

☐ Name ☐ Address
☐ Spouse ☐ Dependent

Employee information

Last Name, First Name, Middle Initial ☐ Male ☐ Female

Street Address Apt

City ST Zip Code

Date of Birth
m m d d y y y y

Social Security Number

m m d d y y y y

Cell Phone
()
m m d d y y y y

List all eligible dependants in order of age, including spouse

Relationship	Full Time Student	Last Name, First Name	M.I.	Gender	Date of Birth
Spouse	<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> M <input type="checkbox"/> F	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> m m d d y y y y
Dependant	<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> M <input type="checkbox"/> F	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> m m d d y y y y
Dependant	<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> M <input type="checkbox"/> F	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> m m d d y y y y
Dependant	<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> M <input type="checkbox"/> F	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> m m d d y y y y

Do you have prescription coverage under another group insurance plan, HMO, or government plan? ☐ Yes ☐ No

If you answered 'Yes', provide insurance carrier name and address: _____

Indicate type of coverage: ☐ Comprehensive Major Medical with Rx ☐ Major Medical Only ☐ Other

Are any other dependants, other than spouse listed above covered by other group insurance plan? ☐ Yes ☐ No

If you answered 'Yes', provide name of insurer, address and policy number: _____

Spouse's Employer: _____ Spouse Insurance Carrier: _____

Spouse Employer Address: _____

By signing this form I authorize Broadreach Medical Resources, Inc. hereafter "BMR" and the service providers for my selected plan to send text messages regarding my membership and services to my cell phone and email to my email address. Text and SMS message and data rates may apply. I am authorized to provide the same consent on behalf of any adult or child listed above. I authorize representatives of BMR to examine all records with respect to myself or any of my dependants which may have a bearing on the benefits payable under the contract(s) applied for. I understand that contract(s) applied for shall not become effective unless this application is accepted and no benefits shall be available prior to the effective date(s) set forth in the certificate issued.

Signature of Employee: _____ Date: _____

Signature of Authorized Employer Representative: _____ Date: _____