CITY OF PONTIAC VEBA TRUST
2027 ENROLLMENT FORM

(This form must be returned to BeneSys by either mail: P.O. Box 4565, Troy, MI 48099-4565, email: enrollmentdocs@benesys.com or by fax: (248) 813-9898 by November 30, 2026)

Select all the categories that are appropriate for both Retiree and Spouse (if Surviving Spouse select that category)

☐ Medicare Retiree	☐ Medicare Spouse	☐ Non-Medicare Retiree	☐ Non-Medicare Spouse	☐ Surviving Spouse

(*required information)

Last Name *	First Name *	MI *	Sex *	Social Security Number *

Street Address *	Apt. No.*	City *	State *	Zip Code *

Date of Birth *	Email Address	Phone Number *

Marital Status *	☐ Single	☐ Married Date of Marriage*	☐ Divorced	☐ Widowed

Medicare Number *		☐	Police & Fire Retiree*	☐	General City Retiree *
Part A Effective Date *	Part B Effective Date *		Date of Retirement*		Date of Retirement *

Dependent Information: *Complete this section ONLY if enrolling a spouse and/or dependent

Relationship to Retiree	Last Name, First Name*	Social Security Number*	Date of Birth*	Medicare Number * (if applicable)
Spouse Male Female				Part A Date: _____ Part B Date: _____
Child Male Female				Part A Date: _____ Part B Date: _____
Child Male Female				Part A Date: _____ Part B Date: _____
Child Male Female				Part A Date: _____ Part B Date: _____

Coverage Selection: ***Select your Medical, HRA, Vision and Dental Coverages**

Medical Plan Options								
BCBSM Medicare Advantage	☐	**Retiree/ Surviving Spouse**	☐	**Spouse**	☐	**Adult Child on Medicare**	☐	**Decline**
BCBSM Pre-65 Non-Medicare	☐	**Retiree/ Surviving Spouse**	☐	**Spouse**	☐	**Family**	☐	**Decline**

New HRA (Health Reimbursement Arrangement) Plan				
HRA (Health Reimbursement Arrangement) $1,000 Annual Benefit	☐	**Retiree/Surviving Spouse ONLY**	☐	**Decline**

Dental Plan								
Delta Dental	☐	**Retiree/ Surviving Spouse**	☐	**Spouse**	☐	**Family**	☐	**Decline**

Vision Plan								
BCBS Vision	☐	**Retiree/ Surviving Spouse**	☐	**Spouse**	☐	**Family**	☐	**Decline**

Authorization: I have elected to enroll myself and my listed dependents in the above medical, HRA, Dental and Vision plans.

Signature: _____ Date: _____

P.O. Box 4565, Troy, MI 48099 4565
Phone: (248) 641 4990 Fax: 248 813 9898
http://www.ourbenefitoffice.com/CityOfPontiac/Benefits