

City of Pontiac VEBA Trust 2026 Enrollment Form

(This Form Must Be Returned to BeneSys by mail: P.O. Box 4565, Troy, MI 48099-4565; by email: enrollmentdocs@benesys.com or by fax: (248) 813-9898 by November 30, 2025)

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

<input type="checkbox"/> Medicare Retiree	<input type="checkbox"/> Medicare Spouse	<input type="checkbox"/> Non-Medicare Retiree	<input type="checkbox"/> Non-Medicare Spouse	<input type="checkbox"/> Surviving Spouse
<i>(* required information)</i>				
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 *	<input type="checkbox"/> Single	<input type="checkbox"/> Married		<input type="checkbox"/> Divorced
	Date of Marriage * _____			
Medicare Number *		<input type="checkbox"/> Police and Fire Retiree *		<input type="checkbox"/> 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 ID Number * <i>(if applicable)</i>
Spouse Male Female				Part A Effective Date: _____ Part B Effective Date: _____
Child Male Female				Part A Effective Date: _____ Part B Effective Date: _____
Child Male Female				Part A Effective Date: _____ Part B Effective Date: _____
Child Male Female				Part A Effective Date: _____ Part B Effective Date: _____
Coverage Selection: *Select your Medical/Vision and Dental Coverage				
BCBS Medicare Advantage with Vision Coverage		BCBS Non-Medicare with Vision Coverage		Delta Dental Coverage
<input type="checkbox"/> Member/Surviving Spouse		<input type="checkbox"/> Member/Surviving Spouse		<input type="checkbox"/> Member/Surviving Spouse
<input type="checkbox"/> Spouse		<input type="checkbox"/> Spouse		<input type="checkbox"/> Spouse
<input type="checkbox"/> Adult Child on Medicare		<input type="checkbox"/> Family		<input type="checkbox"/> Family
<input type="checkbox"/> Decline		<input type="checkbox"/> Decline		<input type="checkbox"/> Decline

Authorization: I have elected to enroll myself and listed dependents in the above medical, vision and/or dental plans.

Signature: _____

Date: _____