BMO Financial Group U.S. Retiree Medical Program

Election / Waiver Form

You only need to complete this form if you are making changes for 2025

Section 1: Retiree Demographic Information

Retiree Name (Please Print)	Address		
Phone Number	Retiree Social Security Number	Reason for Change	Effective Date of Enrollment/Change

Section 2: Member Verification - declare ALL eligible dependents.

Relationship	Name	Gender (circle one)	Social Security Number	Date of Birth	Medicare Eligible (circle one)	Enroll/Waive/Cancel* (circle one)
Retiree		M F			Yes No	Enroll Waive Cancel
Spouse/ Domestic Partner		M F			Yes No	Enroll Waive Cancel
Child		M F			Yes No	Enroll Waive Cancel
Child		M F			Yes No	Enroll Waive Cancel

**Please ensure that you understand the implications your decision may have on your and/or your dependents future eligibility for retiree medical coverage.*

- ***Enroll*** *- By choosing "Enroll" you and/or your eligible dependents are choosing to enroll in a retiree medical plan, please complete Section 3.*
- ***Waive*** *- By choosing "Waive" you are indicating your intent to be enrolled in the Retiree Medical Waiver Provision.*
- ***Cancel*** *- By choosing "Cancel" you are indicating your intent to permanently cancel your coverage and eligibility for the Retiree Medical Program.*

Section 3: Choose your plan - You only need to complete this section if you and/or your eligible dependents will be enrolling in a retiree medical plan.

Medical Plan Options		Covered Members
○ HDHP – BCBSIL *(ALL US)*	○ PPO – BCBSIL *(ALL US)*	
○ HDHP – KAISER *(N. CALIFORNIA)*	○ PPO – KAISER *(N. CALIFORNIA)*	
○ HDHP – KAISER *(S. CALIFORNIA)*	○ PPO – KAISER *(S. CALIFORNIA)*	
○ HDHP – KAISER *(COLORADO)*	○ PPO – KAISER *(COLORADO)*	If individual is under age 65 and Medicare eligible, they are eligible for coverage through Via Benefits and will receive more information on enrollment. Confirm if eligibility is due to:
○ HDHP – KAISER *(OREGON)*	○ PPO – KAISER *(OREGON)*	☐ **Disability** ☐ **End Stage Renal Disease (ESRD)**

Section 4: Certification

I certify that the information provided in this form is accurate and complete. I have read the retiree appendix in the medical Summary Plan Description and understand my election decision. I have verified that my listed dependents are eligible for coverage based on the provisions of the Retiree Medical Program. I understand inaccuracies in the information I have provided can result in permanent cancellation of my retiree medical coverage.

Signature	Date

Please send the completed form by mail or fax to:

BMO Benefits Administration
DEPT 14613, PO Box 64050, The Woodlands, TX 77387-4050
Fax: 1-866-894-6684

The rules of the Retiree Medical Program are complex and subject to change in the future. BMO Financial Group reserves the right to change or end the retiree medical program at any time.