

***BMS LLC***  
*P.O. Box 43653, Louisville, KY 40253-0653*  
*(502) 244-1161 \* FAX (502) 244-1162*  
***Retiree Administration Form***

(Please write legibly.)

**Company Name** \_\_\_\_\_

**Retiree Name:** \_\_\_\_\_

**Retiree Address (city state, zip)** \_\_\_\_\_

**Retiree Social Security #:** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**Retiree Date of Birth:** \_\_\_\_\_

**Date of Hire:** \_\_\_\_\_

**Names of All Covered Beneficiaries and Relationship to Retiree:**

	Date of Birth
	Date of Birth
	Date of Birth

**Benefit Elections**

**Health Insurance** (Indicate if enrolled and Detail Name of Plan Enrolled)

\_\_\_\_\_

If yes, note coverage (E Only, E+Ch, E+Sp, or F) \_\_\_\_\_

Effective Date of Retiree Coverage \_\_\_\_\_

**Dental Insurance** (Indicate if enrolled and Detail Name of Plan Enrolled)

\_\_\_\_\_

If yes, note coverage (E Only, E+Ch, E+Sp, or F) \_\_\_\_\_

Effective Date of Retiree Coverage \_\_\_\_\_

**Other Insurance** (Indicate if enrolled and Detail Name of Plan Enrolled)

\_\_\_\_\_

If yes, note coverage (E Only, E+Ch, E+Sp, or F) \_\_\_\_\_

Effective Date of Retiree Coverage \_\_\_\_\_

**Please notify the Plan Sponsor (BMS LLC) within 10 business days of all retirees or changes in order for them to be added the system timely and to process payment ledgers in a timely manner. (Please be sure to notify us of all address changes as well!)**

Employer Representative Signature: \_\_\_\_\_ Date: \_\_\_\_ - \_\_\_\_ - \_\_\_\_

**Please return this form to:**  
**BMS LLC - Attn: COBRA Administrator**  
**FAX(502)244-1162 OR e-mail: [cobra@bmsllc.net](mailto:cobra@bmsllc.net)**