



BMO Financial Group U.S. Retiree Medical Program

Election / Waiver Form

You only need to complete this form if you are making changes for 2026

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
<input type="radio"/> HDHP – BCBSIL (ALL US) <input type="radio"/> HDHP – KAISER (N. CALIFORNIA) <input type="radio"/> HDHP – KAISER (S. CALIFORNIA) <input type="radio"/> HDHP – KAISER (COLORADO) <input type="radio"/> HDHP – KAISER (OREGON)	<input type="radio"/> PPO – BCBSIL (ALL US) <input type="radio"/> DHMO – KAISER (N. CALIFORNIA) <input type="radio"/> DHMO – KAISER (S. CALIFORNIA) <input type="radio"/> DHMO – KAISER (COLORADO) <input type="radio"/> DHMO – KAISER (OREGON)	<p>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:</p> <p><input type="checkbox"/> Disability <input type="checkbox"/> End Stage Renal Disease (ESRD)</p>

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

BMO Financial Group U.S. Retiree Medical Program
2026 Full Monthly Medical Premiums

Pre-65 Plan Option	Retiree Only or Spouse Only	Retiree + Spouse	Retiree + Child(ren) or Spouse + Child(ren)	Child(ren) Only	Family
HDHP – BCBSIL	\$1,382.40	\$2,764.80	\$2,073.60	\$691.20	\$3,456.00
HDHP – Kaiser (N. California)	\$1,545.29	\$3,399.85	\$2,735.44	-	\$4,589.36
HDHP – Kaiser (S. California)	\$1,202.22	\$2,645.12	\$2,128.22	-	\$3,570.48
HDHP – Kaiser (Colorado)	\$1,189.78	\$2,498.37	\$2,259.99	-	\$3,568.18
HDHP – Kaiser (Oregon)	\$967.01	\$2,127.65	\$1,885.57	-	\$4,020.11

PPO Plan – BCBSIL	\$1,493.10	\$2,986.20	\$2,240.10	\$747.00	\$3,733.20
DHMO Plan – Kaiser (N. California)	\$1,902.18	\$4,185.01	\$3,367.14	-	\$5,649.33
DHMO Plan – Kaiser (S. California)	\$1,479.79	\$3,255.75	\$2,619.51	-	\$4,394.83
DHMO Plan – Kaiser (Colorado)	\$1,464.43	\$3,075.00	\$2,781.69	-	\$4,391.91
DHMO Plan – Kaiser (Oregon)	\$1,190.15	\$2,618.55	\$2,320.69	-	\$4,948.35

To determine your share of the monthly medical premiums, please refer to the [Retiree Medical Program Eligibility and Cost Appendix](#) or your retiree letter for the percentages that you pay.