ENROLLMENT FORM

PLEASE RETURN COMPLETED FORM TO:

BENISTAR RETIREE SERVICE CENTER
10 Tower Lane 1st Floor
Avon, CT 06001
OR Fax this enrollment form to: 1-860-408-7025

☐New Member ☐Current Member	☐Retiree ☐Retiree & Spouse/Domestic Partner ☐Spouse/Surviving Spouse ☐Other (describe)	Effective Date:

EMPLOYEE INFORMATION

Last name:	First name:	MI:	Date of Birth:

Medicare Part A & B Effective Dates: Hospital Part A: Medical Part B:	Do you have End Stage Renal Disease ESRD? Yes No	HIC#/Medicare ID:	Social Security #:

Address:

City: State: Zip:

Former Employer: Home Phone: Cell Phone:

Email Address: Sex: ☐Male ☐Female

COVERAGE INFORMATION

- Check the boxes below to indicate each member to be covered.
- It is <u>not a requirement</u> for members of the same household to enroll in the same Medical and Prescription Drug plans.
- The Dental and Vision coverage <u>requires</u> all members of your household to select the same plan.

Prescription Drug <u>High Plan</u> ☐Retiree ☐Survivor ☐Spouse ☐Domestic Partner	**Prescription Drug <u>Low Plan</u>** ☐Retiree ☐Survivor ☐Spouse ☐Domestic Partner	**Prescription Drug <u>Value Plan</u>** ☐Retiree ☐Survivor ☐Spouse ☐Domestic Partner
Do not select one of these plans if you are enrolling in one of the Transamerica Supplemental Retiree Medical Plans.	**Medicare Advantage $20 Plan with Prescription Drug High Plan** ☐Retiree ☐Survivor ☐Spouse ☐Domestic Partner	**Medicare Advantage $25 Plan with Prescription Drug Low Plan** ☐Retiree ☐Survivor ☐Spouse ☐Domestic Partner

DENTAL COVERAGE

☐Dental Plan	☐Retiree ☐Retiree + Child ☐Retiree + Spouse/Domestic Partner ☐Retiree + Family ☐Other (describe)

VISION COVERAGE

☐Vision Plan	☐Retiree ☐Retiree + Child ☐Retiree + Spouse/Domestic Partner ☐Retiree + Family Other (describe)

IMPORTANT NOTES

- This is a cafeteria style offering, which means you can customize your coverage based upon your needs. You are able to pick and choose your coverage from the various options above, but make sure to note that the Medicare Advantage plans must include a Prescription Drug plan, which is unlike the standalone Prescription Drug plans.
- Dental and Vision are available in combination or with another option but not individually.
- The Medicare Advantage rates are based upon the county that you reside in and utilize a PPL network. You must find out if you reside within the PPO network or in the Extended Service Area, because rates will vary accordingly.
- The Prescription Drug rates are based upon the state that you reside in.
- Please contact the administrator, Benistar @ 1-800-236-4782 to obtain your individual rates. Total rates include the Third Party and VEBA Trust Administrative Fees.
- Make sure to indicate the effective date you would like your coverage to begin and if you are a new or current member.
- Please review all information and sign and date where necessary.
- It is not necessary to include a payment with your initial enrollment form because Benistar will invoice you after you have successfully enrolled.

DEPENDENT INFORMATION:

*Please list full name of Medicare Eligible dependents to be covered under Medical, Dental, Vision, and Pharmacy as applicable.

Dependent #1:

Last name:	First name:	MI:	Date of Birth:
Medicare Part A & B Effective Dates: Hospital Part A: Medical Part B:	Do you have End Stage Renal Disease ESRD? ☐Yes ☐No	HIC#/Medicare ID:	Social Security #:
Relationship to Retiree:			Sex: ☐Male ☐Female

Dependent #2:

Last name:	First name:	MI:	Date of Birth:
Medicare Part A & B Effective Dates: Hospital Part A: Medical Part B:	Do you have End Stage Renal Disease ESRD? ☐Yes ☐No	HIC#/Medicare ID:	Social Security #:
Relationship to Retiree:			Sex: ☐Male ☐Female

EMPLOYEE AUTHORIZATION AND SIGNATURE:

For Medicare Advantage Plan Enrollees:

By completing this enrollment application, I agree to the following:

The Aetna Medicare PPO Plan is a Medicare Advantage plan that has a contract with the Federal government. I will need to keep my Medicare Parts A and B. I can only be in one Medicare Advantage plan at a time and I understand that my enrollment in this plan will automatically end my enrollment in another Medicare Advantage health plan.

Disclosure:

I understand that beginning on the date my Medicare Advantage plan coverage begins, using In-Network can cost less than using services Out-of-Network, except for emergency or urgently needed services or Out-of-Area dialysis services. Services authorized by the Aetna Medicare Plan (PPO) and other services contained in my Aetna Medicare Plan (PPO) Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization where required, neither Medicare nor the Aetna Medicare Plan will pay for the services.

Release of Information

By joining this Medicare Advantage plan, I acknowledge that my information will be released to Medicare and other plans as is necessary for the treatment, payment, and health care operations. I also acknowledge that Aetna Medicare will release my information, including prescription drug event data to Medicare, who may release it for research and other purposes which follow all applicable Federal statutes and regulations.

For all coverage's requested, I acknowledge the information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information, I will be unenrolled from this plan.

I understand that my signature (or signature of the person authorized to act on behalf of the individual under the laws of the State where the individual resides) on this application means that I have read and understand the contents of this application. If signed by an authorized individual (as described above), this signature certifies that: 1) this person is authorized under State law to complete this enrollment and 2) documentation of this authority is available upon request by applicable plan vendors or by Medicare.

Attestation:

Your signature is verification that:

- You are an Eligible Auto Beneficiary and can supply supporting documentation upon request.
- You are enrolled in both Medicare Parts A and B.

FRAUD WARNING

Any person who knowingly and with intent to defraud any insurance company or other persons: 1) files an application of insurance company or statement of claim containing any materially false information, or 2) conceals for the purpose of misleading information concerning any material fact thereto, commits a fraudulent insurance act.

Retiree Signature _____ Date _____

Dependent Signature _____ Date _____