HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY

One Hartford Plaza
Hartford, CT 06155
(A stock insurance company)

Group Retiree Insurance Plan® Enrollment Form
For Initial Enrollment and Subsequent Changes

Policyholder: Steel Retiree VEBA Trust **Policy Numbers:** AGP-30188, AGP-30189

Please print clearly in ink or type

Retiree's Name: _____
First Middle Last

Street: _____

City, State, Zip: _____ Medicare/HIC # _____

Phone Number: _____ Email Address: _____

Gender ☐ Male ☐ Female Date of Birth _____ Social Security # _____

Date of Retirement _____ Have you enrolled in Medicare Part B? ☐ Yes ☐ No

If no, when do you intend to enroll? _____

Dependent Spouse's Name (Only if enrolling): _____
First Middle Last

Gender ☐ Male ☐ Female Date of Birth _____ Social Security # _____

Medicare/HIC # _____ Date of Retirement _____

Has your dependent spouse enrolled in Medicare Part B? ☐ Yes ☐ No

If no, when does he/she intend to enroll? _____

To the best of your knowledge:

1. Do you or your dependent spouse, if enrolling, have or are eligible for any other health insurance including an employer health plan? **Retiree** ☐ Yes ☐ No **Dependent Spouse** ☐ Yes ☐ No

If so, with which company? _____

What kind of policy? _____

Covered Person	Company Name	Policy Number	Kind of Policy	Effective Date	Expiration Date

2. If the answer to question 1 is yes, do you or your dependent spouse, if enrolling intend to replace these medical or health policies with this policy or certificate? **Retiree** ☐ Yes ☐ No **Dependent Spouse** ☐ Yes ☐ No

   If yes, for what reason are you (or your dependent spouse, parent or child, if enrolling) replacing the coverage?

   ☐ Additional Benefits
   ☐ Fewer benefits and lower premiums
   ☐ Integration with Medicare
   ☐ No change in benefits, but lower premiums
   ☐ Other (please specify)

3. Are you covered by Medicaid?
   Retiree ☐ Yes ☐ No **Dependent Spouse** ☐ Yes ☐ No

Check Desired Coverage:

	Premium Plus AGP-30188	Premium Choice AGP-30189
Retiree	☐	☐
Dependent Spouse	☐	☐

Complete this form answering all questions. Please be sure to date and sign the form and return to:

Benistar Administrative Services, Inc.
10 Tower Lane, Suite 100
Avon, CT 06001

Confirmation
I acknowledge that I have been given the opportunity to enroll in the insurance offered by my employer. I understand and agree that if I decline insurance now, I may not be able to enroll in the future.

I understand and agree that insurance will go into effect and remain in effect only in accordance with the provisions, terms and conditions of the insurance policy. I understand and agree that only the insurance policy issued to my Employer can fully describe the provisions, terms, conditions, limitations and exclusions of my insurance. In the event of any difference between the enrollment form and the insurance policy, I agree to be bound by the insurance policy.

Fraud Notice(s)
For Residents of Florida:
Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

For Residents of Louisiana:
Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

For Residents of Maryland:
Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

For Residents of New York (Not applicable to Life Insurance):
Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

For Residents of Virginia:
It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Date: _____ Retiree Signature: _____

Date: _____ Dependent Spouse Signature:_____
(if enrolling)