Voluntary Benefit Trust for AIRLINE RETIREES

This is a electronic fillable form. Please complete by typing in your information and signing electronically.

Client Name: Airline TAA certified worker, PBGC recipient or Trust Subsidiary VEBA Trust

CONE RETIREE HEALTHCARE GROUP

Pre-65 Age 55-64 Insurance Enrollment Form

Carriers: Blue Cross Blue Shield of Michigan (BCBSM) - Medical, Prescription Drug, Dental and Blue Vision **TAA certified worker or PBGC recipient and Spouse have the ability to enroll individually in a plan with/without different levels of coverage as a Single person enrolling in the plan if they desire**. If electing to enroll as 1 individual, each plan participant must pay their individual administrative fee.

*****Select the Coverage for the individual(s) enrolling in the plan below under one (1) Enrollment form if you are a Trust Subsidiary, TAA certified worker or PBGC recipient and/or Spouse and/or Dependent enrolling in the plan as a Single. If two (2) or less people are enrolling in the plan, selecting enrollment as a single on two (2) forms offers better pricing. Each family member must complete their own form and send payment individually for their plan options.**

Section I: Enrollee Information

Are you electing the same health plan that you are currently utilizing? ☐ Yes ☐ No

Who is enrolling?

☐ Trust Subsidiary (Association, Group) ☐ TAA certified worker or PBGC recipient only ☐ TAA certified worker or PBGC recipient and Spouse/Domestic partner ☐ TAA certified worker or PBGC recipient and family ☐ Spouse/Domestic Partner ☐ Dependent

TAA certified worker or PBGC recipient Information (All Information in *Italics* Below Applies ONLY to the TAA certified worker or PBGC recipient)

Last name	*First name*	*M.I.*	*Date of birth*
Address	*City*	*State*	*Zip code*
Daytime telephone number	*Social Security Number*	*Email Address*	*Sex (M or F)*
Medicare # if Applicable:		*Medicare Effective Date:*	

☐ *Salaried* ☐ *Hourly* *Name of Union if Hourly:*

Effective date . Form of Payment* ☐ Money Order ☐ Check

*Must be received by the 1st day of the month of the Effective Date

*Initial enrollment options for 2019: (1) 100% premium payment for 1st month (72.5% of the premium will be reimbursed if you file it on your 2019 tax return). (2) Enrollment with a future start date after IRS certification in the HCTC program. You will receive an enrollment letter verifying your entry into the HCTC program.

Section II: List All Dependents That Are Enrolling –

***** Relationship code S (Spouse), SS (Surviving Spouse), DP (Domestic Partner), C (Child by birth or adoption), D (Disabled Child)**

Name (First, MI, Last)	Relationship Code***	Sex	Date of Birth	Full-Time Student	SSN

Section III: Tips To Help You Complete Your Coverage Elections

1) **You can find a complete listing of the 2020 rates on the included enrollment worksheet. Please review these rates before selecting your coverage.**
2) **When selecting your coverage please check each box that pertains to the coverage you and/or dependents elect. For example—if you are selecting the Gold or Silver Plans for both TAA certified worker and Spouse you will need to check both the TAA certified worker and Spouse box. If you are selecting the Gold Plan for both TAA certified worker and Child, you will need to check both the TAA certified worker and Child box. If you are enrolling as a Spouse or Child only, you need to check the appropriate box. All enrollees are eligible if the TAA certified worker, PBGC recipient or Trust Subsidiary is qualified and they can enroll as Standalone participants however, they must complete the TAA certified worker, PBGC recipient or Trust Subsidiary box and the Dependents box in order to verify HCTC eligibility.**
3) **Family Coverage is coverage including three or more individuals.**
4) **Please review all information and sign and date where necessary.**

Section IV: Select Your Coverage

Effective Date for Coverage (Enter MM): ____/01/2020 **You MUST select an Effective Date to start coverage**

Gold Plan Bundled: Medical, Prescription Drug, Dental and Vision

☐ TAA certified worker, PBGC recipient or Trust Subsidiary ☐ Spouse / Domestic Partner ☐ Child ☐ Family

Silver Plan Bundled: Medical, Prescription Drug, Dental and Vision

☐ TAA certified worker, PBGC recipient or Trust Subsidiary ☐ Spouse / Domestic Partner ☐ Child ☐ Family

Bronze Plan Bundled: Medical, Dental and Vision

☐ TAA certified worker, PBGC recipient or Trust Subsidiary ☐ Spouse / Domestic Partner ☐ Child ☐ Family

Copper Plan Bundled: Medical, Prescription Drug, Dental and Vision

☐ TAA certified worker, PBGC recipient or Trust Subsidiary ☐ Spouse / Domestic Partner ☐ Child ☐ Family

Copper Plan Unbundled: Medical and Prescription Drug

☐ TAA certified worker, PBGC recipient or Trust Subsidiary ☐ Spouse / Domestic Partner ☐ Child ☐ Family

Dental and Vision Only:

☐ TAA certified worker, PBGC recipient or Trust Subsidiary ☐ Spouse / Domestic Partner ☐ Child ☐ Family

PLEASE READ THE FOLLOWING INFORMATION. THE INFORMATION ON THIS FORM AND THE FOLLOWING CONDITIONS ARE PART OF MY CONTRACT WITH BLUE CROSS BLUE SHEILD OF MICHIGAN (BCBSM).

I am applying for coverage for myself and/or my family member indentified on this application under my group's or association's contract with BCBSM. Coverage begins on the date determined by BCBSM. When BCBSM accepts my application, I and covered members of my family are bound by the terms on the policy and this application. I understand that the submission of false or misleading information or the omission of material information on this form may result in rejection of my enrollment or retroactive termination of my coverage. **Proof of eligibility:** I agree to provide proof of my dependent's eligibility for coverage when requested by BCBSM.

Authorization: I appoint my group or association to handle all matters of coverage. It may forward deductions from my wages. I am responsible for giving notice to my group or association of changes in my status and/or my family's status that affect coverage, such as marriage, divorce, birth, Medicare entitlements, or death of someone covered under the policy. I authorize BCBSM and/or my Primary Care Physician to obtain the medical records relating to me and my enrolled family members necessary for the coordination of our medical care, administration of my coverage with BCBSM, and for other purposes necessary for BCBSM to fulfill its contractual and statutory obligations.

Release of Information: I acknowledge that BCBSM requires me to provide my Social Security Number. In applying for coverage, I and my enrolled family members agree to permit providers and others to release "protected health information" (as that term is used in the Health Insurance Portability and Accountability Act of 1996, as amended) to BCBSM for purposed of administering our coverage. Upon my request, BCBSM will tell me where the information was sent.

TAA certified worker, PBGC recipient or Trust Subsidiary Signature: (if enrolling)

_____ Date: _____

Spouse Signature: (if enrolling)

_____ Date: _____

This enrollment form in conjunction with form 13441A must be completed in their entirety in order to be enrolled in the HCTC program. Any missing information will delay your enrollment. Coverage will be effective upon IRS certification in the HCTC program.

Instructions for form completion:

Complete form by either (a) printing a blank form and filling in all necessary information in ink or (b) open the form and complete electronically (you are also able to sign your form electronically). Don't forget to save your form on your computer once you have completed.

Completed forms can be emailed to Benistar at: memelig@benistar.com
If faxing send to: 1-860-408-7025
If mailing send to:
Benistar TAA certified worker or PBGC recipient Service Center
10 Tower Lane, Suite 100
Avon, CT. 06001

***Please make your check payable to* US Treasury - HCTC**