Group Retiree Heal Hartford Life & Accident Insurance Company	th Insurance Plan Enrollmer Policy Numbers:	nt Form			
Policyholder: Auto Trust Airline Trust Steel Trust (Please print clearly in ink or type)					
Retiree's Name:	iddle Last				
City, State, Zip:		y # :			
Medicare ID#: Gender: Male Female Date of Birth _		# :			
Spouse's Name (Only if enrolling):	Middle	Last Security #:			
Spouse Medicare ID#					

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Please check the medical plan you are enrolling:

	Choice	Premium	Premium Plus	Elite
Retiree				
Spouse				

Complete this form answering all questions. Please be sure to date and sign the form and return to: Benistar Administrative Services, Inc. (BASI) 10 Tower Lane, First Floor Avon, CT 06001 1-800-236-4782

I (we) understand and agree that any pre-existing conditions (conditions for which medical advice or treatment has been received or recommended in the past six months) will not be covered until six consecutive months after the effective date of coverage. I (we) understand that if I (we) plan on replacing any existing group medical coverage with this plan, then this pre-existing condition limitation will be waived to the extent it was satisfied under the previous policy. I (we) understand that coverage will become effective on the first day of the month following receipt by the Company of this enrollment form and first premium payment.

Date:	Retiree Signature:	
Date:	Spouse Signature:	
		(if enrolling)