



**Pre-65 Benefit Enrollment and Change of Status Form**

**Auto Retiree VEBA Trust**

**\*THE HCTC PROGRAM HAS NOT BEEN EXTENDED. ALL PLAN PARTICIPANTS WILL HAVE TO PAY 100% OF THE PLAN PREMIUM UNLESS/UNTIL THE HCTC PROGRAM IS EXTENDED\***

This is an electronic fillable form. Please complete by typing in your information and signing electronically or print, complete and sign.

Carrier: Blue Cross Blue Shield of Michigan (BCBSM) – Medical, Prescription Drug, Dental and Blue Vision. PBGC Recipient, Spouse/Domestic Partner, Two Person, Dependent or Qualified Family Member(QFM) have the ability to enroll individually in any plan level of coverage as a Single person if they desire.

\*Select the Coverage for the individual(s) enrolling in the plan below under one (1) Enrollment form if you are a PBGC recipient and/or Spouse and/or Dependent enrolling in the plan as a Family. If two (2) people are enrolling in the plan, selecting enrollment as a single on two (2) forms offers better pricing. The two family members are not required to have the same coverage if they enroll individually. Each family member must complete their own form and send payment individually for their plan options.

Pre-65 and Post-65 participants in stand alone Dental +/- Vision plans must complete this form to enroll or make changes to existing coverage.

**SECTION I: Type of Request**

<input type="checkbox"/> Non HCTC	<input type="checkbox"/> Dental +/- Vision Enrollment or Change* *Pre-65 and Post-65 stand alone Dental +/- Vision enrollees including Post-65 participants
<input type="checkbox"/> Change of Status <input type="checkbox"/> Address Change <input type="checkbox"/> Add Dependent <input type="checkbox"/> Terminate Contract <input type="checkbox"/> Other _____	

**SECTION 2: Enrollee Information**

Are you electing the same health plan that you are currently utilizing? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Who is enrolling?		<input type="checkbox"/> PBGC recipient only <input type="checkbox"/> PBGC recipient and Spouse/Domestic partner <input type="checkbox"/> PBGC recipient and Family <input type="checkbox"/> Spouse/Domestic Partner <input type="checkbox"/> Dependent		
Last Name	First Name	M.I.	Date of Birth (mm/dd/yyyy) / /	
Address		City	State	Zip
Telephone Number		Social Security Number		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
Medicare ID Number if Applicable:	Medicare Effective Date	Medicare Currently Enrolled: <input type="checkbox"/> Part A <input type="checkbox"/> Part B		Email Address
Spouse/Dependent Medicare ID Number if Applicable:		Spouse/Dependent Medicare Effective Date		
Retirement Date	Salary / Hourly <input type="checkbox"/> Salary <input type="checkbox"/> Hourly		If Hourly, Name of Union	
Company Retired From				
Effective Date / /		Form of Payment    *Must be received by the 10 <sup>th</sup> day of the month of the Effective Date <input type="checkbox"/> Check (only form of payment accepted by IRS/HCTC AMP) <input type="checkbox"/> EFT (Non-AMP option only)		
<input type="checkbox"/> Auto VEBA Trust QFM Eligible		Retiree Name*		Retiree Date of Birth* / /

\*If you are enrolling and not the Retiree, include Retiree's Name and Date of Birth and Retirement Date from Auto in the provided fields above.



SECTION 3: Participating Dependent(s)

Name (First, MI, Last)	DOB (mm/dd/yyyy)	SSN	Gender	Relationship Code <sup>1</sup>
			<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> S <input type="checkbox"/> SS <input type="checkbox"/> DP <input type="checkbox"/> C <input type="checkbox"/> D
			<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> S <input type="checkbox"/> SS <input type="checkbox"/> DP <input type="checkbox"/> C <input type="checkbox"/> D
			<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> S <input type="checkbox"/> SS <input type="checkbox"/> DP <input type="checkbox"/> C <input type="checkbox"/> D
			<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> S <input type="checkbox"/> SS <input type="checkbox"/> DP <input type="checkbox"/> C <input type="checkbox"/> D

<sup>1</sup> Relationship Codes – S (Spouse); SS (Surviving Spouse); DP (Domestic Partner); C (Child by Birth or Adoption); D (Disabled Child)

SECTION 4: Medical Coverage Selection

Select your coverage by choosing one box in this section. For HCTC-eligible AMP qualifying members, only Medical/Dental/Vision benefits must be selected.

**MEDICAL COVERAGE**

Pre-65 & Pre-65 Medicare Disabled ONLY. For Post-65 Medical, please contact Benistar 1-800-236-4782 or complete the Post-65 Enrollment Form.

GOLD				
Medical / Dental / Vision				Terminate Coverage
<input type="checkbox"/>				<input type="checkbox"/>

SILVER – Only medical plan available to pre-65 Medicare Disabled				
Medical / Dental / Vision	Medical / Dental	Medical / Vision	Medical Only	Terminate Coverage
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

BRONZE				
Medical / Dental / Vision	Medical / Dental	Medical / Vision	Medical Only	Terminate Coverage
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

COPPER				
Medical / Dental / Vision	Medical / Dental	Medical / Vision	Medical Only	Terminate Coverage
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**DENTAL / VISION - HARTFORD OR MEDICARE ADVANTAGE COVERAGE**

High Dental / Vision	High Dental Only	Vision Only	Terminate Coverage
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Low Dental / Vision	Low Dental Only	Vision Only	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

**DENTAL / VISION - STAND-ALONE COVERAGE**

High Dental / Vision	High Dental Only	Vision Only	Terminate Coverage
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Low Dental / Vision	Low Dental Only	Vision Only	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

SECTION 5: Signature

Retiree Signature:  
(If Enrolling)

Date:

Spouse/Domestic Partner Signature:  
(If Enrolling)

Date:

**ONLY APPLIES IF/WHEN HCTC PROGRAM IS REAUTHORIZED**

Attention HCTC AMP participants - This enrollment form in conjunction with form 1344I-A must be completed in their entirety and proof of eligibility (i.e.- 1099-R) included in order to be enrolled in the HCTC program. Any missing information will delay your enrollment in being processed. All enrollment forms, including the 1344I-A form if needed, will be faxed, emailed or mailed to Benistar. Use the contact information in "Instructions for Completion and Submittal of ALL Forms" on Page 3 of this form.

## SECTION 6: Plans and Rates – Non HCTC

### NON-HCTC AMP ELIGIBLE RETIREES UNDER AGE 65

Total cost includes medical, prescription drug, high dental, and vision which maximizes benefits for retirees and qualified dependents eligible for the Health Coverage Tax Credit (HCTC)



PLAN		MONTHLY PREMIUM
GOLD PLAN	Gold Single	\$1,601.71
	Gold Family	\$4,761.79
SILVER PLAN	Silver Single	\$1,427.94
	Silver Family	\$4,240.47
BRONZE PLAN	Bronze Single	\$1,138.09
	Bronze Family	\$3,370.89
COPPER PLAN	Copper Single	\$937.65
	Copper Family	\$2,769.59

### STANDALONE NO MEDICAL Dental & Vision Rates Under Age 65 -

#### LOW PLAN

	Dental /Vision	Dental Only
Single	\$73.03	\$64.41
Two Person	\$141.82	\$124.57
Family	\$243.44	\$214.81

These rates **INCLUDE** the \$4.25 admin fee

#### HIGH PLAN

	Dental /Vision	Dental Only
Single	\$80.58	\$71.96
Two Person	\$156.92	\$139.67
Family	\$269.87	\$241.24

These rates **INCLUDE** the \$4.25 admin fee

#### Blue Cross Blue Shield Vision Rates (VSP)

Single	\$ 8.62
Two-Person	\$ 17.25
Family	\$ 28.63

MUST be purchased with a Dental Plan

### STANDALONE NO MEDICAL Dental & Vision Rates Hartford / Medicare Advantage-

#### Dental Rates (Standalone or with another option)

The rates below are priced for eligible plan participants enrolling in the Dental Plan Only.

	Low Dental	High Dental
Single	\$60.16	\$64.21
Two Person	\$120.32	\$128.42

No admin fee when adding Dental to Hartford or BCBSM Medicare Advantage.

#### Blue Cross Blue Shield Vision Rates (VSP)

Single	\$ 6.99
Two-Person	\$ 13.98

MUST be purchased with a Dental Plan

Note: The Pre-65 spouse of a Medicare eligible retiree must fill out a separate Auto VEBA Trust Enrollment form if the retiree is signing up for Dental +/- Vision. Post-65 dental enrollees must include their Medicare number in section 2 to receive the Post-65 price.

### The Health Coverage Tax Credit Expired

To date, the Health Coverage Tax Credit (HCTC) has not been extended and funding continues to not be available. If Congress fails to extend the HCTC program before December 1, 2022, and you wish to remain in the AUTO VEBA insurance plans, be prepared to pay 100% of the plan premium for each month the HCTC program is not in operation. If Congress extends the HCTC Program after the open enrollment period, there will be a special open enrollment period available at a later date.

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### SECTION 7: Terms & Conditions

**Please Read the following information. The information on this form and the following conditions are part of my contract with Blue Cross® Blue Shield® of Michigan.**

I am applying for coverage for myself and/or my family member identified on this application under my group's or association's contract with Blue Cross. Coverage begins on the date determined by Blue Cross. When Blue Cross 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 Blue Cross Blue Shield of Michigan. **Authorization:** I appoint my group or association to handle all matters of coverage. I am responsible for giving notice to Blue Cross® Blue Shield® of Michigan 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 Blue Cross 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 Blue Cross, and for other purposes necessary for Blue Cross to fulfill its contractual and statutory obligations.

**Release of Information:** I acknowledge that Blue Cross 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 Blue Cross for purpose of administering our coverage. Upon my request, Blue Cross will tell me where the information was sent.

### **Instructions for Completion and Submittal of ALL Forms**

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 able to sign your form electronically or by printing). Don't forget to save your form on your computer once you have completed.

**Contact Benistar with any question 1-800-236-4782**

**Completed forms can be faxed or emailed to Benistar at: [memelig@benistar.com](mailto:memelig@benistar.com)**

**Or if faxing send to: 1-860-408-7025**

**If mailing send to:**  
Benistar Service Center  
10 Tower Lane, Suite 100  
Avon, Ct. 06001