VBTAR Enrollment Form - (Pre 65)

Voluntary Benefit Trust for AIRLINE RETIREES

1. Name: _____ _____ _____
   First Name *Middle Name* *Last Name*

   Address _____ _____ _____
   Street *City* *State*

2. Date of Birth: ____ ____ ____ _____
   MM *DD* *YY* Retirement Date:

   _____ _____
   Telephone Number *Email Address*

☐ Male ☐ Female
Gender

Insurance Start Date: ____ ____ ____ _____
MM *DD* *YY* Name of Company Retired From

DOB of Eligible Retiree ____ ____ ____ _____
MM *DD* *YY* *Name of Eligible Retiree*

**If you are enrolling and not the Retiree, include Retiree's Name and Date of Birth*

☐ *Male* ☐ *Female* ☐ *S* ☐ *SS* ☐ *DP* ☐ *C* ☐ *D*

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

Medicare Id Number if Applicable: _____ Medicare Currently Enrolled: Part A ☐ Part B ☐

Medicare Effective Date: _____

Please complete your information, sign and return.

Medical carriers offered: Blue Cross Blue Shield and MetLife.

Members: Retiree, Spouse/Domestic Partner, Surviving Spouse or Dependent have the ability to enroll individually in 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 qualifying member 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.

****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****

3. Type of Enrollment

☐ New Enrollment (Bundled Medical, RX, Dental & Vision or Selected Medical Pairings)
☐ Dental+/-Vision
☐ Life Insurance
☐ New Enrollment (NON-Bundled Plan(s))

4. Change of Status

☐ Address Change
☐ Terminate Coverage
☐ Add Dependent
Other _____

5. Enrollee Information

☐ Eligible Retiree
☐ Eligible Retiree and Souse/Domestic Partner
☐ Eligible Retiree and Family (3+)
☐ Spouse/Domestic Partner
☐ Dependent

Voluntary Benefit Trust for AIRLINE RETIREES

6. Plan Options - Blue Cross Blue Shield Plans

BUNDLED PLAN OPTIONS

BUNDLED Medical, RX, Vision & High Dental Plan

- ☐ New Enrollment COPPER Plan
- ☐ New Enrollment BRONZE Plan
- ☐ New Enrollment SILVER Plan
- ☐ New Enrollment GOLD Plan

- ☐ Terminate (COPPER Bundled High Dental Plan)
- ☐ Terminate (BRONZE Bundled High Dental Plan
- ☐ Terminate (SILVER Bundled High Dental Plan)
- ☐ Terminate (GOLD Bundled High Dental Plan)

BUNDLED Medical, RX, Vision & Low Dental Plan

- ☐ New Enrollment COPPER Plan
- ☐ New Enrollment BRONZE Plan
- ☐ New Enrollment SILVER Plan
- ☐ New Enrollment GOLD Plan

- ☐ Terminate (COPPER Bundled Low Dental Plan)
- ☐ Terminate (BRONZE Bundled Low Dental Plan)
- ☐ Terminate (SILVER Bundled Low Dental Plan)
- ☐ Terminate (GOLD Bundled Low Dental Plan)

UNBUNDLED PLAN OPTIONS

Medical, Vision & High Dental

- ☐ New Enrollment COPPER Plan — ☐ Terminate
- ☐ New Enrollment BRONZE Plan — ☐ Terminate
- ☐ New Enrollment SILVER Plan — ☐ Terminate

Medical, Vision & Low Dental

- ☐ New Enrollment COPPER Plan — ☐ Terminate
- ☐ New Enrollment BRONZE Plan — ☐ Terminate
- ☐ New Enrollment SILVER Plan — ☐ Terminate

Medical & High Dental

- ☐ New Enrollment COPPER Plan — ☐ Terminate
- ☐ New Enrollment BRONZE Plan — ☐ Terminate
- ☐ New Enrollment SILVER Plan — ☐ Terminate

Medical & Low Dental

- ☐ New Enrollment COPPER Plan — ☐ Terminate
- ☐ New Enrollment BRONZE Plan — ☐ Terminate
- ☐ New Enrollment SILVER Plan — ☐ Terminate

Medical & Vision Only

- ☐ New Enrollment COPPER Plan — ☐ Terminate
- ☐ New Enrollment BRONZE Plan — ☐ Terminate
- ☐ New Enrollment SILVER Plan — ☐ Terminate

Medical ONLY

- ☐ New Enrollment COPPER Plan — ☐ Terminate
- ☐ New Enrollment BRONZE Plan — ☐ Terminate
- ☐ New Enrollment SILVER Plan — ☐ Terminate

Medicare Eligible Medical, Dental & Vision

- ☐ New Enrollment HARTFORD Plan — ☐ Terminate
- ☐ New Enrollment BCBS Plan — ☐ Terminate

Medicare Eligible

- ☐ New Enrollment - High Dental Only — ☐ Terminate
- ☐ New Enrollment - Low Dental Only — ☐ Terminate
- ☐ New Enrollment - High Detnal/Vision — ☐ Terminate
- ☐ New Enrollment - Low Dental/Vision — ☐ Terminate

Dental & Vision ONLY

- ☐ New Enrollment Vision Plan — ☐ Terminate Vision Plan
- ☐ New Enrollment HIGH DENTAL Plan — ☐ Terminate HIGH DENTAL Plan
- ☐ New Enrollment LOW DENTAL Plan — ☐ Terminate LOW DENTAL Plan

By signing below you are also agreeing to the Terms and Conditions.

7. Signature _____ Date of Signature _____ (MM / DD / YY)

Voluntary Benefit Trust for AIRLINE RETIREES

❒ 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 and/or The Hartford.

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 and/or The Hartford. Coverage begins on the date determined by Blue Cross and/or The Hartford. When the carrier(s) accept(s) 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 and/or The Hartford.

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 and/or The Hartford 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,The Hartford and/or my Primary Care Physician to obtain the medical records relating to me and my enrolled family members necessary for the coordination of mine/our medical care, administration of my coverage with Blue Cross and/or The Hartford, and for other purposes necessary for Blue Cross and/or The Hartford to fulfill its contractual and statutory obligations.

Release of Information: I acknowledge that Blue Cross and/or The Hartford requires me to provide my Social Security Number. In applying for coverage, I and/or 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 and/or The Hartford for purpose of administering our coverage.

Instructions for Completion and Submittal of ALL Forms

Complete form by printing a blank form and filling in all necessary information.

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

Completed forms can be faxed or emailed to Benistar at: 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

Blue Cross Blue Shield – Medical Plan Options

Pre 65 / 2024 Rates

COPPER Plan	Medical, RX, High Dental and Vision Rate	Medical, RX, Low Dental and Vision Rate	Medical, RX and Low Dental	Medical and RX only
Single	$1,023.15	$1,015.83	$1,006.94	$948.60
Family	$3,025.14	$2,999.51	$2,970.00	$2,765.81

BRONZE Plan	Medical, RX, High Dental and Vision Rate	Medical, RX, Low Dental and Vision Rate	Medical, RX and Low Dental	Medical and RX only
Single	$1,243.87	$1,236.55	$1,227.66	$1,169.32
Family	$3,687.30	$3,661.67	$3,632.16	$3,427.97

SILVER Plan	Medical, RX, High Dental and Vision Rate	Medical, RX, Low Dental and Vision Rate	Medical, RX and Low Dental	Medical and RX only
Single	$1,579.12	$1,571.80	$1,562.91	$1,504.57
Family	$4,693.03	$4,667.40	$4,637.89	$4,433.70

GOLD Plan	Medical, RX, High Dental and Vision Rate	Medical, RX, Low Dental and Vision Rate
Single	$1,769.86	$1,762.54
Family	$5,265.25	$5,239.62

Gold Plan is only offered as a Bundled Benefit:
-Medical, RX, HIGH Dental & Vision
-Medical, RX, LOW Dental & Vision

The rates above include the administration fee

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 you wish to remain in your VEBA Trust insurance plans, you will 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.

Blue Cross Blue Shield - Dental / Vision
(Standalone no Medical) Pre 65 / 2024 Rates

Retirees Under Age 65 -

LOW PLAN		
	Dental /Vision	Dental Only
Single	$71.48	$62.59
Two Person	$138.71	$120.93
Family	$237.95	$208.44

An administration fee of $4.25 is included above

HIGH PLAN		
	Dental /Vision	Dental Only
Single	$78.80	$69.91
Two Person	$153.35	$135.57
Family	$263.58	$234.07

An administration fee of $4.25 is included above

Blue Cross Blue Shield – Medicare Disabled
Pre 65 / 2024 Rates

The rates below only apply to **pre-65 Medicare disabled** members.

SILVER	Medical / High Dental / Vision	Medical /High Dental	Medical / Vision	Medical Only
Single	$2,372.78	$2,361.65	$2,310.51	$2,303.31

The rates above include the administration fee

Blue Cross Blue Shield – Medicare Disabled
(Standalone no Medical) Pre 65 / 2024 Rates

Medicare Disabled Retirees or Eligible Dependents Under Age 65 Retirees Post 65

LOW PLAN		
	Dental /Vision	Dental Only
Single	$69.79	$62.59
Two Person	$135.33	$120.93

An administration fee of $4.25 is included above

HIGH PLAN		
	Dental /Vision	Dental Only
Single	$73.72	$66.52
Two Person	$143.19	$128.79

An administration fee of $4.25 is included above

Coverage Contact Information

Benistar

Phone: 1(800)236-4782

Your Call Center and Plan Administrator

Mailing Address for Enrollment Forms :
Benistar Retiree Service Center
10 Tower Lane, Suite100
Avon, CT 06001
(do not send checks to this address)

Fax Enrollment Forms:
(860)408-7025

Medical Plan Information:

Blue Cross Blue Shield Medical Plans

Blue Cross Blue Shield of Michigan	
Post-Enrollment Benefits and Claims	
Benistar Call Center	(800)236-4782
BCBSM Claims Department	(877)354-2583

Prescription Drug Plan Information:

Blue Cross Blue Shield Prescription Drug Plans

BCBSM Pre-Enrollment Benefit Inquiries:	(800)236-4782
Post-Enrollment Benefits & Claims	
Prescription Drug Formulary	(877)354-2583

Dental Plan Information:

Blue Cross Blue Shield Nationwide Plans (Dental)

Blue Cross Blue Shield of Michigan	
www.Mibluedentist.com	
Dental Customer Service Find a Doctor	(888)826-8152

Vision Plan Information:

Blue Cross Blue Shield Michigan (Blue Vision VSP with BCBSM)

BCBSM Customer Service	(800)877-7195
www.VSP.com or www.BCBSM.com	

All billing / payment information will be listed on your Benistar invoice.