# 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*

Social Security Number: _____ ☐ Male ☐ Female
*Gender*

Insurance Start Date: ____ ____ ____
*MM* *DD* *YY*

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

Name of Company Retired From _____

*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.*