Voluntary Benefit Trust for AIRLINE RETIREES

MEDICARE ELIGIBLE ENROLLMENT FORM

Section A: Member Information

Retiree Name: (First) (Middle) (Last)	Gender: Male ☐ Female ☐	Social Security Number:	Date of Birth: (mm/dd/yyyy)
Spouse Name: (First) (Middle) (Last)	Gender: Male ☐ Female ☐	Social Security Number:	Date of Birth: (mm/dd/yyyy)
Address: (Street) (City) (State) (Zip)			Phone Number:
Email Address:	Are you Eligible for Medicare: ☐ Yes ☐ No		
Medicare Currently Enrolled: ☐ Part A ☐ Part B	Medicare ID Number: (If applicable)		
Medicare Effective Date:	If Wating on Medicare # check here: ☐		

Please complete your information, sign and return.
The effective date of your coverage will be the first of the month following your signature date, but not prior to the month in which you become Medicare Eligible. If you become Medicare Eligible on the 1st day of the month, your coverage is effective on the 1st of the month prior. The exception to this is if you are enrolling through our annual open enrollment period. In this case, the effective date of coverage would be 1/1/2025.

To elect Medical coverage, you must complete The Hartford Enrollment Form in addition to this form. The Hartford form is included in the enrollment packet and can also be found on the Turst website-go to www.MyMedPlans.com and click on 'Post 65 Plans". You may select medical ONLY coverage, prescription drug ONLY coverage or medical coverage with prescription drug plans.

Your spouse/domestic partner can elect different medical/prescription coverage as the Retiree.
To elect Medical coverage, you must complete The Hartford Enrollment Form in addition to this form. The Hartford form is included in the enrollment packet and can also be found on the Trust website-go to www.MyMedPlans.com and click on 'Post 65 Plans" under your Trust title.

Section B: Enrollment Action

- ☐ Enroll BCBSM - Medicare Advantage
- ☐ Enroll Hartford Supplemental Plan
- ☐ Enroll Dental / Vision
- ☐ Enroll Life Insurance

Section C: Change of Status

- ☐ Address Change
- ☐ Add Member
- ☐ Terminate Coverage
- ☐ Other

Section D: Enrollee Information

- ☐ Eligible Retiree
- ☐ Eligible Retiree & Spouse / Domestic Partner
- ☐ Spouse / Domestic Partner / Surviving Spouse

Section E: Medicare Eligible Plan Options

BCBSM - Medicare Advantage

(Enroll)

- ☐ Diamond Plan
- ☐ Emerald Plan
- ☐ Ruby Plan

(Terminate)

- ☐ *Diamond Plan*
- ☐ *Emerald Plan*
- ☐ *Ruby Plan*

- ☐ Retiree
- ☐ Spouse, Domestic Partner Surviving Spouse

The Hartford Medicare Supplemental Plan

Complete this form and additional Hartford Enrollment Form

BCBSM - Standalone PDP

(Enroll)

- ☐ High PDP
- ☐ Low PDP

(Terminate)

- ☐ *High PDP*
- ☐ *Low PDP*

- ☐ Retiree
- ☐ Spouse, Domestic Partner
  Surviving Spouse

BCBSM - Medicare Eligible Dental and/or Vision ONLY

(Enroll)

- ☐ High Dental
- ☐ Low Dental
- ☐ High Dental with Vision
- ☐ Low Dental with Vision

(Terminate)

- ☐ *High Dental*
- ☐ *Low Dental*
- ☐ *High Dental with Vision*
- ☐ *Low Dental with Vision*

- ☐ Retiree
- ☐ Spouse, Domestic Partner
  Surviving Spouse

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

Signature: Date:

Print Name:

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. By joining anoy of the plans, I acknowledge that my information will be released to Medicare and other plans as is necessary for treatment, payment and health care operations. The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information, I will be dis-enrolled from any plan. I understand that my signature (or signature of the person authorized to act on behalf of the individual under the laws of the State where the individual resides) on this application means that I have read and understand the contents of this application. If signed by an authorized individual (as described above), this signature certifies that: 1) this person is authorized under State law to complete this enrollment and 2) documentation of this authority is available upon request by applicable plan vendors or by Medicare. 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 Benistar and 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:
Email: memelig@benistar.com
Fax: 1-860-408-7025

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