Voluntary Benefit Trust for AIRLINE RETIREES

# Pre-65 Benefit Enrollment and Change of Status Form

## Voluntary Benefit Trust for Airline Retiree VEBA Trust

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 1: Type of Request

| ☐ Non HCTC | ☐New Enrollment – Non AMP* | ☐HCTC AMP* Enrollment or Change | ☐ Dental +/- Vision Enrollment or Change* |
|---|---|---|---|
| | *If you have not initiated your PBGC pension payments or if you elect to receive the HCTC subsidy yearly via IRS form 8885 check here. | *Advanced Monthly Payment (AMP) enrollment must include proof of eligibility with this form. | *Pre-65 and Post-65 stand alone Dental +/- Vision enrollees including Post-65 participants |

☐Change of Status
☐ Address Change ☐ Add Dependent ☐Terminate Contract ☐Other_____

## ❒ SECTION 2: Enrollee Information ☐

Are you electing the same health plan that you are currently utilizing? ☐ Yes ☐ No

Who is enrolling? ☐ PBGC recipient only ☐PBGC recipient and Spouse/Domestic partner ☐PBGC recipient and Family ☐Spouse/Domestic Partner ☐ Dependent

| Last Name | First Name | M.I. | Date of Birth (mm/dd/yyyy) / / |
|---|---|---|---|
| Address | City | State | Zip |
| Telephone Number | Social Security Number | Gender ☐ Male ☐ Female | |
| Medicare ID Number if Applicable: | Medicare Effective Date | Medicare Currently Enrolled: ☐ Part A ☐ Part B | Email Address |
| Spouse/Dependent Medicare ID Number if Applicable: | Spouse/Dependent Medicare Effective Date | | |
| Retirement Date | | Salary / Hourly ☐ Salary ☐ Hourly | If Hourly, Name of Union |
| Company Retired From | | | |
| Effective Date / / | Form of Payment *Must be received by the 10th day of the month of the Effective Date ☐ Check (only form of payment accepted by IRS/HCTC AMP) ☐ EFT (Non-AMP option only) | | |
| ☐ VBTAR 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 VBTAR in the provided fields above.

## ❒ SECTION 3: Participating Dependent(s)

| Name (First, MI, Last) | DOB (mm/dd/yyyy) | SSN | Gender | Relationship Code [1] |
|---|---|---|---|---|
| | | | ☐ M ☐ F | ☐ S ☐ SS ☐ DP ☐ C ☐ D |
| | | | ☐ M ☐ F | ☐ S ☐ SS ☐ DP ☐ C ☐ D |
| | | | ☐ M ☐ F | ☐ S ☐ SS ☐ DP ☐ C ☐ D |
| | | | ☐ M ☐ F | ☐ S ☐ SS ☐ DP ☐ C ☐ D |

1 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 |
|---|---|
| ☐ | ☐ |

**SILVER – Only medical plan available to pre-65 Medicare Disabled**

| Medical / Dental / Vision | Medical / Dental | Medical / Vision | Medical Only | Terminate Coverage |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ |

**BRONZE**

| Medical / Dental / Vision | Medical / Dental | Medical / Vision | Medical Only | Terminate Coverage |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ |

**COPPER**

| Medical / Dental / Vision | Medical / Dental | Medical / Vision | Medical Only | Terminate Coverage |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ |

### STAND-ALONE COVERAGE

| High Dental / Vision | High Dental Only | Vision Only | Terminate Coverage |
|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ |
| **Low Dental / Vision** | **Low Dental Only** | **Vision Only** | |
| ☐ | ☐ | ☐ | |

## ❒ SECTION 5: Signature

**Retiree Signature: (If Enrolling)** _____ **Date:** _____

**Spouse/Domestic Partner Signature: (If Enrolling)** _____ **Date:** _____

Attention HCTC AMP participants - This enrollment form in conjunction with form 13441-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 13441-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.

**[End of Enrollment Form to be Submitted. Return pages 1 - 2 only.]**

## ❒ SECTION 6: Plans and Rates – Non HCTC

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

| | BUNDLED PLANS (MEDICAL, PRESCRIPTION DRUG, DENTAL AND VISION) | | TOTAL MONTHLY PREMIUM |
|---|---|---|---|
| 1 | GOLD PLAN | Gold Single | $1,571.09 |
| | | Gold Family | $4,663.66 |
| 2 | SILVER PLAN | Silver Single | $1,375.47 |
| | | Silver Family | $4,076.79 |
| 3 | BRONZE PLAN | Bronze Single | $1,046.81 |
| | | Bronze Family | $3,090.80 |
| 4 | COPPER PLAN | Copper Single | $911.23 |
| | | Copper Family | $2,684.07 |

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

| Dental Rates (Standalone or w/ another option) | Low Dental | High Dental |
|---|---|---|
| The rates below are priced for eligible plan participants enrolling in the Dental Plan Only. | | |
| Single | $56.59 | $63.70 |
| Two-Person | $113.19 | $127.40 |
| Family | $198.08 | $222.94 |
| When enrolling in Dental Only, an Administration Fee of $4.25 must be added to the rate. | | |

| 2021 Blue Cross Blue Shield Vision Rates (VSP) | | |
|---|---|---|
| Single | $ 6.51 | These Rates do NOT include the admin fee |
| Two-Person | $ 13.02 | |
| Family | $ 21.61 | |
| If purchased separately must be bundled with Vision plan and pay admin fee of $4.25 | | |

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

| 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 | $56.59 | $60.41 |
| Two-Person | $113.18 | $120.82 |
| Family | $169.77 | $181.23 |
| If purchased separately must be bundled with Vision plan and pay admin fee of $4.25 | | |

| 2021 Blue Cross Blue Shield Vision Rates (VSP) | | |
|---|---|---|
| Single | $ 5.28 | These Rates do NOT include the admin fee |
| Two-Person | $ 10.56 | |
| Family | $ 15.84 | |
| If purchased separately must be bundled with Vision plan and pay admin fee of $4.25 | | |

Note: The Pre-65 spouse of a Medicare eligible retiree must fill out a separate VBTAR 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.

## ☑SECTION 7: Eligibility Requirements for HCTC Advanced Monthly Payment (AMP) Program

1. The Advance Monthly payment (AMP) program allows you to pay 27.5% of the premium to the IRS directly. The IRS then pays the entire premium for your insurance.
2. Retiree Eligibility: To be eligible for the HCTC, you must meet one of the following:
   a. An eligible trade adjustment assistance recipient, alternative TAA recipient or reemployment TAA recipient,
   b. An eligible Pension Benefit Guaranty Corporation payee, or
   c. The family member of an eligible TAA, ATAA, or RTAA recipient or PBGC payee who is deceased or who finalized a divorce with you.
3. You are not eligible for the HCTC if you:
   a. Can be claimed as a dependent on another person's federal income tax return or
   b. Are enrolled in Medicare, Medicaid, the Children's Health Insurance Program, or the Federal Employees Health Benefits Program or are eligible to receive benefits under the U.S. military health system (TRICARE)
4. Qualified Family Member (QFM) Eligibility: To be eligible for the HCTC, you must be a family member of a Retiree who is eleigible for 24 months from the event date of one of the following:
   a. Retiree begins Medicare (Medicare care required)
   b. Retiree Death (death certificate required). Note: If the Surviving Spouse option was chosen, the spouse is eligible for the HCTC until they turn 65.
   c. Divorce (divorce decree required). Note: If the spouse is receiving a portion of the PBGC pension they are eligible for the HCTC until they turn 65,
5. For more information on VBTAR VEBA, HCTC, or AMP registration including sample completed forms, visit www.HCTCPlans.com or www.irs.gov/hctc or call Benistar at (800)236-4782.

## ❒ SECTION 8: HCTC Plans and Rates

**HCTC AMP ELIGIBLE RETIREES UNDER AGE 65**

| | | BUNDLED PLANS (MEDICAL, PRESCRIPTION DRUG, DENTAL AND VISION) | TOTAL MONTHLY PREMIUM |
|---|---|---|---|
| 1 | GOLD PLAN | Gold Single | $1,571.09 |
| | | Gold Family | $4,663.66 |
| 2 | SILVER PLAN | Silver Single | $1,375.47 |
| | | Silver Family | $4,076.79 |
| 3 | BRONZE PLAN | Bronze Single | $1,046.81 |
| | | Bronze Family | $3,090.80 |
| 4 | COPPER PLAN | Copper Single | $911.23 |
| | | Copper Family | $2,684.07 |

### Sunset of the Health Coverage Tax Credit

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, 2020, the program will shutdown for a minimum of 1-2 months into 2021 or until reauthorization is passed. If you wish to remain in the VBTAR 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.

## ❒ SECTION 9: 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**

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

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