RETIREE MEDICAL PLAN OPTION RATES – *coverage through The Hartford. Enrollers must continue to pay their Medicare Part B premium.*

☐ I would like to waive Medical coverage.

Plan Options	Election Options - *check off both Retiree and Spouse coverage if electing both*	
Premium Plan	☐ Retiree Coverage Age: under 65 $330.55 Age: 65-69 $230.88 Age 70+ $330.55	☐ Spouse or Surviving Spouse Coverage Age: under 65 $330.55 Age: 65-69 $230.88 Age 70+ $330.55
Value Plan	☐ Retiree Coverage Age: under 65 $235.00 Age: 65-69 $171.08 Age 70+ $235.00	☐ Spouse or Surviving Spouse Coverage Age: under 65 $235.00 Age: 65-69 $171.08 Age 70+ $235.00

PRESCRIPTION DRUG COVERAGE - *coverage through Express Scripts Medicare ™. Enrollees in Prescription Drug Coverage must continue to pay their Medicare Part B premium.*

☐ I would like to waive Prescription Drug coverage.

Choice Plan	☐ Retiree Only	$168.30
	☐ Spouse Only or Surviving Spouse Only Coverage	$168.30
	☐ Retiree & Spouse Coverage	$336.60

DENTAL PLAN OPTIONS - *coverage through MetLife Dental PPO*

☐ I would like to waive Dental coverage.

Dental Plan	☐ Retiree Only	$56.30
	☐ Spouse Only or Surviving Spouse Only Coverage	$56.30
	☐ Retiree & Spouse Coverage	$112.60

VISION PLAN OPTIONS - *coverage through Superior Vision*

☐ I would like to waive Vision coverage.

Vision Plan	☐ Retiree Only	$7.62
	☐ Spouse Only or Surviving Spouse Only Coverage	$7.62
	☐ Retiree & Spouse Coverage	$14.68

Note: There is a $1.00 VEBA Trust fee , $1.25 Health Services Hub benefit, and a $2.72 Silver&Fit Fitness benefit (Retiree Medical Option only), which will be billed as a separate line item in addition to the rates shown above.

Complete the following information if electing Medical, Prescription, Dental or Vision coverage.

Retiree's Name: _____
First Middle Last

Retiree's Street Address: _____

Retiree's City, State, Zip: _____

Retiree's Mailing Address: _____
(if different the above)

Mailing City, State, Zip: _____

Retiree Date of Birth: ____/____/____ Retiree SSN: ____-____-____ Retiree Retirement Date: ____/____/____

Gender: ☐ Male ☐ Female **Email:** _____

By providing your email address, you authorize the VEBA and Carriers to send you electronic communications.

Telephone: _____

Retiree Medicare #: _____ (Exactly as it appears on your Medicare card)

Medicare Part A Effective Date (Found on Medicare Card) Medicare Part B Effective Date (Found on Medicare Card)

_____ _____
Month Day Year Month Day Year

Spouse's Name: _____
First Middle Last

Spouse's Street Address: _____

City, State, Zip: _____

Spouse's Mailing Address: _____
(if different the above)

Mailing City, State, Zip: _____

Spouse Date of Birth: ____/____/____ Spouse SSN: ____-____-____

Telephone: _____

Spouse Medicare #: _____ **Spouse Retirement Date: ____/____/____**
(Exactly as it appears on your Medicare card)

Medicare Part A Effective Date (Found on Medicare Card) Medicare Part B Effective Date (Found on Medicare Card)

_____ _____
Month Day Year Month Day Year

Please answer the following:

1. Do you have any other current health insurance, including an employer or union health plan?

   Retiree ☐ Yes ☐ No Spouse ☐ Yes ☐ No

2. If YES, with which company or union? Please indicate below:

Person Covered	Company Name	Policy #	Type of Policy	Effective Date	Expiration Date

3. If the answer to question 1 is YES, do you intend to replace these Medicare Supplement or medical policies with this policy or certificate? ☐ Yes ☐ No

Note: If the answer to question 2 is NO and you intend to continue coverage in another Medicare Supplement or employer/union group health plan, please be aware this Group Retiree Insurance Plan does not coordinate benefits with any other coverage.

4. Are you covered by Medicaid? (This is different than Medicare.) ☐ Yes ☐ No

5. Do you have any other prescription drug coverage including State Pharmaceutical Assistance Program? ☐ Yes ☐ No

6. If YES, please list other coverage and your identification number(s):

Name of Coverage	ID # for Coverage	Group # for Coverage

Confirmation

I acknowledge that I have been given the opportunity to enroll in the insurance offered by the Policyholder. I understand and agree that if I decline insurance now, I may not be able to enroll in the future.

I understand and agree that insurance will go into effect and remain in effect only in accordance with the provisions, terms and conditions of the insurance policy. I understand and agree that only the insurance policy issued to the Policyholder can fully describe the provisions, terms, conditions, limitations and exclusions of my insurance. In the event of any difference between the enrollment form and the insurance policy, I agree to be bound by the insurance policy.

Fraud Notice(s)

For Residents of Louisiana:

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

For Residents of Maryland:

Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

For Residents of New York:

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

For Residents of Virginia:
It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Please sign below. You must sign for your requested elections to take effect.

X _____ **X** _____

Retiree Signature _____ **Date Signed**

X _____ **X** _____

Spouse/Surviving Spouse Signature (if enrolling) **Date Signed**

If you have any questions, please contact the Airlines Retiree Benefit Plan Service Center at (844)-413-1989. Representatives are available Monday through Friday from 8:00 a.m. to 5:00 p.m. (Eastern time).

If you have made a change in coverage, return the entire form to:
AIRLINE RETIREE BENEFIT PLAN
Administered by Benistar Admin Services
10 Tower Lane, Suite 100; Avon, CT 06001