Medicare Supplement Insurance Enrollment Form

Hartford Life and Accident Insurance Company

Policy Numbers: AGP- 20088, AGP-24088, AGP-25088

Policyholder: Voluntary Benefit Trust for Airline Retirees

Please print clearly in ink or type

Retiree's Name: _____
First Middle Last

Street: _____ City, State, Zip: _____

Sex ☐ Male ☐ Female Date of Birth _____ Medicare HIC # _____

Date of Retirement _____ Social Security # _____

Spouse's Name (Only if enrolling): _____
First Middle Last

Street: _____ City, State, Zip: _____

Sex ☐ Male ☐ Female Date of Birth _____ Medicare HIC # _____

Date of Retirement _____ Social Security # _____

If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare supplement insurance policy, or that you had certain rights to buy such a policy, you may be guaranteed acceptance in one or more of our Medicare supplement plans. Please include a copy of the notice from your prior insurer with your application.

PLEASE ANSWER ALL QUESTIONS.

Please mark Yes or No below with an "X"

To the best of your knowledge:

1. (A) In the last six months, did you turn age 65?

   Retiree: ☐Yes ☐ No Spouse: ☐Yes ☐ No

   (B) In the last six months, did you become eligible for Medicare by reason of disability or end stage renal disease?

   Retiree: ☐Yes ☐ No Spouse: ☐Yes ☐ No

2. Did you enroll in Medicare Part B in the last 6 months?

   Retiree: ☐Yes ☐ No Spouse: ☐Yes ☐ No

   If yes, what is the effective date? Retiree ____/_____/____ Spouse ____/_____/____

3. Are you covered for medical assistance through the state Medicaid program?

   Retiree: ☐Yes ☐ No Spouse: ☐Yes ☐ No

   (NOTE TO APPLICANT: If you are participating in a "Spend-Down Program" and have not met your "Share of Cost," please answer NO to this question.)

   Retiree: ☐Yes ☐ No Spouse: ☐Yes ☐ No

   If yes,

   A) Will Medicaid pay your premiums for this Medicare supplement policy?

      Retiree: ☐Yes ☐ No Spouse: ☐Yes ☐ No

   B) Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium?

      Retiree: ☐Yes ☐ No Spouse: ☐Yes ☐ No

4. If you had coverage under any Medicare plan other than the original Medicare within the last 63 days (for example, a Medicare Advantage plan, or a Medicare HMO or PPO), fill in your start and end dates below. If you are still covered under this plan, leave "END" blank.

   Retiree:
   START ___/___/____ END ___/___/____

   Spouse:
   START ____/___/____ END ___/___/____

5. If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare supplement policy?

Retiree: ☐ Yes ☐ No Spouse: ☐ Yes ☐ No

6. Was this your first time in this type of Medicare plan?

   Retiree: ☐ Yes ☐ No Spouse: ☐ Yes ☐ No

7. Did you drop a Medicare supplement policy to enroll in the Medicare plan?

   Retiree: ☐ Yes ☐ No Spouse: ☐ Yes ☐ No

8. Do you have another Medicare supplement policy in force?

   Retiree: ☐ Yes ☐ No Spouse: ☐ Yes ☐ No

   A) If so, with what company and what plan do you have?

   Retiree: _____ Policy Number: _____

   Spouse: _____ Policy Number: _____

   B) If so, do you intend to replace your current Medicare supplement policy with this policy?

   Retiree: ☐ Yes ☐ No Spouse: ☐ Yes ☐ No

9. Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union, or individual plan)

   Retiree: ☐ Yes ☐ No Spouse: ☐ Yes ☐ No

   A) If so, with what company and what kind of policy?

   Retiree: _____ Policy Number: _____

   Spouse: _____ Policy Number: _____

   B) What are your dates of coverage under the policy (If you are still covered under the other policy, leave "END" blank.)?

   Retiree:
   START ___/___/____ END ___/___/____

   Spouse:
   START ____/___/____ END ___/___/____

10. Have you smoked cigarettes, cigars, or used pipe or chewing tobacco, nicotine chewing gum or snuff during the past 12 months?

    Retiree: ☐ Yes ☐ No Spouse: ☐ Yes ☐ No

NOTE TO AGENT IDENTIFIED AT BOTTOM OF THIS FORM: List any other health insurance policies you have issued to the retiree or spouse named above:

A) Policies which are still in force: _____

B) Policies issued in the past five (5) years which are no longer in force: _____

PLEASE NOTE

(1) You, or your Spouse do not need more than one Medicare supplement policy.
(2) If you purchase this certificate, you may want to evaluate your existing health coverage and decide if you need multiple coverages.
(3) You may be eligible for benefits under Medicaid and may not need a Medicare supplement policy.

(4) If, after purchasing this certificate, you become eligible for Medicaid, the benefits and premiums under your Medicare supplement certificate can be suspended if requested during your entitlement to benefits under Medicaid for twenty-four months. You must request this suspension within ninety days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare supplement certificate (or, if that is no longer available, a substantially equivalent certificate) will be reinstituted if requested within ninety days of losing Medicaid eligibility. If the Medicare supplement certificate provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your certificate was suspended, the reinstituted certificate will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
(5) If you are eligible for, and have enrolled in a Medicare supplement certificate by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare supplement certificate can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare supplement certificate under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare supplement certificate (or, if that is no longer available, a substantially equivalent certificate) will be reinstituted if requested within 90 days of losing your employer or union-based group health plan. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while certificate was suspended, the reinstituted certificate will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
(6) Counseling services may be available in your state to provide advice concerning your purchase of Medicare supplement insurance and concerning medical assistance through the state Medicaid program, including benefits as a "Qualified Medicare Beneficiary" (QMB) and a "Specified Low-Income Medicare Beneficiary" (SLMB).

IMPORTANT: SMOKING STATUS WILL DETERMINE RATES FOR YOU AND YOUR SPOUSE.

✔ Please check desired coverage:

	Plan A		**Plan F**		**Plan G**	
	Tobacco user	Non-user	Tobacco user	Non-user	Tobacco user	Non-user
Retiree	☐	☐	☐	☐	☐	☐
Spouse	☐	☐	☐	☐	☐	☐

Complete this form answering all questions. Please be sure to date and sign the form and return it to:

Benistar Administrative Services, Inc. (BASI)
10 Tower Lane, Suite 100
Avon, CT 06001
860-408-7000

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

I (we) understand and agree that any pre-existing conditions (conditions for which medical advice or treatment has been received or recommended in the past six months) will not be covered until six consecutive months after the effective date of coverage. I (we) understand that coverage will become effective on the first day of the month following receipt by the Company of this enrollment form and first premium payment.
The Company will waive the Pre-Existing Condition Limitation to the extent that it was met under any prior Medicare Supplement policy. If this plan replaces another Medicare Supplement Policy which has been in effect for at least six (6) months, the Company will not exclude benefits based on a Pre-Existing Condition.

Date: _____ Retiree Signature: _____

Date: _____ Spouse Signature: _____
(if enrolling)

AGENT INFORMATION

Name: _____ Signature: _____

Florida License Identification Number: _____