

Group Retiree Health Insurance Plan Enrollment Form Hartford Life & Accident Insurance Company Policy Numbers:

Policyholder: Steel Trust
(Please print clearly in ink or type)
Retiree's Name:  First Middle Last  Street:
City, State, Zip:Social Security # :
Medicare ID#:
Gender: Male Female Date of Birth Phone #:
Spouse's Name (Only if enrolling):  First Middle Last
Gender: Male Female Date of Birth Social Security #:
Spouse Medicare ID#
Please check the medical plan you are enrolling:    Premium Choice   Retiree   Spouse   Spous
Complete this form answering all questions. Please be sure to date and sign the form and return to: Benistar Administrative Services, Inc. (BASI) 10 Tower Lane, First Floor Avon, CT 06001 1-800-236-4782
I (we) understand and agree that any pre-existing conditions (conditions for which medical advice of treatment has been received or recommended in the past six months) will not be covered until so consecutive months after the effective date of coverage. I (we) understand that if I (we) plan on replacing any existing group medical coverage with this plan, then this pre-existing condition limitation will be waived to the extent it was satisfied under the previous policy. I (we) understand that coverage with become effective on the first day of the month following receipt by the Company of this enrollment for and first premium payment.
Date: Retiree Signature:
Date: Spouse Signature: (if enrolling)