MEDICAL ENROLLMENT FORM - PRE 65

Auto Retiree VEBA Trust

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)
Dependant Name: (First) (Middle) (Last)	Gender: Male ☐ Female ☐	Social Security Number:	Date of Birth: (mm/dd/yyyy)
Address: (Street) (City) (State) (Zip)			Phone Number:
Insurance Start Date:			
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.
Medical carriers offered: Blue Cross Blue Shield
Members: Retiree, Spouse/Domestic Partner, Surviving Spouse or Dependent have the ability to enroll individually for coverage in these plans 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 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) f orms (offers better pricing). The two family members are not required to have the same coverage if they enroll individually. Each family member m ust complete their own form and send payment individually for their plan options.

Section B: Enrollment Action

☐ Enroll Bundled Medical, RX, Dental & Vision or Selected Medical Pairings
☐ Enroll Dental / Vision
☐ Enroll Non Bundled Plans

Section C: Change of Status

☐ Address Change
☐ Terminate Coverage
☐ Add Dependent
☐ Other

Section D: Enrollee Information

☐ Eligible Retiree
☐ Spouse / Domestic Partner / Surviving Spouse Dependent
☐ Eligible Retiree & Spouse / Domestic Partner
☐ Eligible Retiree & Family (3+)

Section E: Medical Plan Options

BCBSM - Bundled Plans with **High** Dental

(Enroll)	*(Terminate)*
☐ Copper Plan	☐ *Copper Plan*
☐ Bronze Plan	☐ *Bronze Plan*
☐ Silver Plan	☐ *Silver Plan*
☐ Gold Plan	☐ *Gold Plan*

BCBSM - Bundled Plans with **Low** Dental

(Enroll)	*(Terminate)*
☐ Copper Plan	☐ *Copper Plan*
☐ Bronze Plan	☐ *Bronze Plan*
☐ Silver Plan	☐ *Silver Plan*
☐ Gold Plan	☐ *Gold Plan*

BCBSM - Unbundled Plans

Medical & High Dental

(Enroll)	*(Terminate)*
☐ Copper Plan	☐ *Copper Plan*
☐ Bronze Plan	☐ *Bronze Plan*
☐ Silver Plan	☐ *Silver Plan*

Medical & Low Dental

(Enroll)	*(Terminate)*
☐ Copper Plan	☐ *Copper Plan*
☐ Bronze Plan	☐ *Bronze Plan*
☐ Silver Plan	☐ *Silver Plan*

Medical & Vision

(Enroll)	*(Terminate)*
☐ Copper Plan	☐ *Copper Plan*
☐ Bronze Plan	☐ *Bronze Plan*
☐ Silver Plan	☐ *Silver Plan*

Medical ONLY

(Enroll)	*(Terminate)*
☐ Copper Plan	☐ *Copper Plan*
☐ Bronze Plan	☐ *Bronze Plan*
☐ Silver Plan	☐ *Silver Plan*

Medicare Eligible

(Enroll)	*(Terminate)*
☐ Hartford Plan	☐ Hartford Plan
☐ Blue Cross Blue Shield Plan	☐ Blue Cross Blue Shield

Dental & Vision ONLY

(Enroll)	*(Terminate)*
☐ High Dental Plan	☐ High Dental Plan
☐ Low Dental Plan	☐ Low Dental Plan

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

Signature: Date:

Print Name:

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.

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 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: 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