



Seniors Choice Group Retiree Medical & Rx Enrollment Form



Offered through the Merchants Industry Fund Group Insurance Trust

Enrollee Information: (Attach a copy of Medicare ID Card)

Member Name: _____
First MI Last

Sex: Male Female

Street Address: _____

City, State, Zip: _____ Req. Eff. Date: ____/____/____

Medicare Claim # (HIC#): _____ SSN #: ____/____/____

Sponsoring Entity Name: _____

Telephone #: (____) _____ Date of Birth: ____/____/____

Are you currently employed: No By your Sponsoring Entity By Another Employer FT PT

Are you currently covered under any employer / union provided group medical plan, Medicare Supplement Plan or Medicare Advantage Plan?: Yes No

If yes, in order to be eligible for Seniors Choice you must terminate this coverage on or before the requested effective date.

Are you currently enrolled in a Prescription Drug Plan?: Yes No

If "Yes", Plan Type: Medicare Part D Medicare Advantage Employer/Union Group Plan Discount Drug Plan

If "Yes", Plan Name: _____ Carrier Name: _____

Medical Plan Selection: (You can only enroll in a deductible option that has been elected by your sponsoring entity.)

- | | | |
|--|---|---|
| <input type="checkbox"/> \$0 Deductible Plan | <input type="checkbox"/> \$500 Deductible Plan | <input type="checkbox"/> \$2000 Deductible Plan |
| <input type="checkbox"/> \$100 Deductible Plan | <input type="checkbox"/> \$750 Deductible Plan | <input type="checkbox"/> \$2500 Deductible Plan |
| <input type="checkbox"/> \$150 Deductible Plan | <input type="checkbox"/> \$1000 Deductible Plan | <input type="checkbox"/> \$3000 Deductible Plan |
| <input type="checkbox"/> \$250 Deductible Plan | <input type="checkbox"/> \$1500 Deductible Plan | <input type="checkbox"/> \$4000 Deductible Plan |

Prescription Plan Selection: (You can only enroll in a Prescription Plan that has been elected by your sponsoring entity.)

- Choice Prescription Drug Plan Preferred Prescription Drug Plan Premier Prescription Drug Plan

Spouse/Domestic Partner Information: (Attach a copy of Medicare ID Card)

Member Name: _____
First MI Last

Sex: Male Female

Street Address: _____

City, State, Zip: _____ Req. Eff. Date: ____/____/____

Medicare Claim # (HIC#): _____ SSN #: ____/____/____

Telephone #: (____) _____ Date of Birth: ____/____/____

Are you currently employed: No By your Sponsoring Entity By Another Employer FT PT

Are you currently covered under any employer / union provided group medical plan, Medicare Supplement Plan or Medicare Advantage Plan? Yes No

If yes, in order to be eligible for Seniors Choice you must terminate this coverage on or before the requested effective date.

Are you currently enrolled in a Medicare Advantage Prescription Drug or Part D Plan?: Yes No

If "Yes", Plan Type: Medicare Part D Medicare Advantage Employer/Union Group Plan Discount Drug Plan

If "Yes", Plan Name: _____ Carrier Name: _____

Medical Plan Selection: (You can only enroll in a deductible option that has been elected by your sponsoring entity.)

- | | | |
|--|---|---|
| <input type="checkbox"/> \$0 Deductible Plan | <input type="checkbox"/> \$500 Deductible Plan | <input type="checkbox"/> \$2000 Deductible Plan |
| <input type="checkbox"/> \$100 Deductible Plan | <input type="checkbox"/> \$750 Deductible Plan | <input type="checkbox"/> \$2500 Deductible Plan |
| <input type="checkbox"/> \$150 Deductible Plan | <input type="checkbox"/> \$1000 Deductible Plan | <input type="checkbox"/> \$3000 Deductible Plan |
| <input type="checkbox"/> \$250 Deductible Plan | <input type="checkbox"/> \$1500 Deductible Plan | <input type="checkbox"/> \$4000 Deductible Plan |

Prescription Plan Selection: (You can only enroll in a Prescription Plan that has been elected by your sponsoring entity.)

- Choice Prescription Drug Plan Preferred Prescription Drug Plan Premier Prescription Drug Plan

Terms and Conditions of Enrollment:

Seniors Choice is not a Medicare Supplement Plan. Seniors Choice is an Employer Group Retiree Medical Plan that coordinates with Medicare. You must be age 65 or over and be enrolled in Medicare Parts A & B to participate in this program. If you have a Medicare Supplement plan, you may not need both the Medicare Supplement plan and the Seniors Choice Employer Group Retiree Program.

On behalf of myself, and my eligible dependents, I am requesting enrollment under the Senior Choice Plans offered through my former or (or current TEFRA eligible) employer. By signing this enrollment application, I agree to and understand the following:

- 1) **Medical Coverage:** Subject to the terms and conditions of the GTL Master Policy.
- 2) **Medical Coverage:** GTL or its designee shall have access to and use of my and my dependents medical records for purposes of utilization review, processing claims, financial audit or other purposes reasonably related to the performance of this Enrollment form.
- 3) **Medical Coverage:** Do not cancel existing medical coverage until approved in writing by MBA, Inc. During the time that you are covered by an employer's health plan that is primary to Medicare, the Seniors Choice plan will not provide coverage.
- 4) **Prescription Coverage:** Is offered by Medco Containment Life Insurance Company. The Medicare Prescription Drug Coverage is administered by Medco Medicare Prescription Plan which is a creditable Part D Plan as governed by CMS.
- 5) **Prescription Coverage:** By joining this Medicare Prescription Drug Plan, I acknowledge that Medco Medicare Prescription Plan will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that Medco Medicare Prescription Plan will release my information, including my prescription drug event date, to Medicare, who may release it for research and other purposes which follow all applicable Federal statutes and regulations.
- 6) **The Seniors Choice Prescription Drug Plan** is a Medicare drug plan and is in addition to my coverage under Medicare; therefore, I will need to keep my Medicare coverage. It is my responsibility to inform the Seniors Choice Prescription Drug Plan of any prescription drug coverage that I have or may get in the future. I can only be in one Medicare prescription drug plan at a time. If I am currently in a Medicare prescription drug plan, my enrollment in the Seniors Choice Prescription Drug Plan will end that enrollment. Enrollment in this plan is generally for the entire year. I may leave this plan only at certain times of the year, or under certain special circumstances, by sending a request to:
 - 1) The Seniors Choice Prescription Drug Plan or by calling 1-800-Medicare, 24 hours per day, 7 days per week.
 - 2) TTY users should call 1-877-486-2048. Final approval of the effective date of enrollment is determined by CMS.
- 7) **Prescription Coverage:** I understand that if I leave this plan and do not have or obtain other Medicare prescription drug coverage or creditable coverage (as good as Medicare's), I may have to pay a late enrollment penalty in addition to my premium for Medicare prescription drug coverage in the future.
- 8) **Prescription Coverage:** Once I am a member of Medco Medicare Prescription Plan, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from Medco Medicare Prescription Plan when I receive it to know which rules I must follow in order to receive coverage with this Medicare drug plan.
- 9) The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be dis-enrolled from the plan.
- 10) I understand that my signature (or the signature of the person authorized to act on behalf of the individual under the laws of the State where the individual resides) on this application means that I have read and understand the contents of this application. If signed by an authorized individual (as described above), this signature certifies that:
 - 1) This person is authorized under State law to complete this enrollment and
 - 2) Documentation of this authority is available upon request by the Seniors Choice Prescription Drug Plan or by Medicare.
- 11) 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.
- 12) A retiree or the dependent spouse or domestic partner of a retiree must: (a) be age 65 or older, (b) be covered under Medicare Parts A and B, (c) not be eligible for Medicaid, (d) not be covered under a Medicare Supplement policy or certificate, (e) not be covered by an employer's health plan which is primary to Medicare due to employment of such person, and (f) not be confined to a Hospital or Skilled Nursing Home on the effective date of coverage. If a retiree or dependent spouse is confined to a Hospital or Skilled Nursing Home on the effective date of coverage, coverage will be delayed until the day after the date of release from the Hospital or Skilled Nursing Home.

Member Signature: _____ Date: _____
Spouse / Domestic Partner Signature: _____ Date: _____

For more information, contact Seniors Choice at (800) 800-6543 or visit www.seniorschoiceplan.com

Pre-Authorized Check (PAC) Draft Authorization

Return this form and a voided check in the enclosed envelope OR FAX to: (480) 776-5055

As a convenience to me, I authorize **MBA, Inc.** administrator of **Seniors Choice**, to debit premiums and, if necessary, make adjustments for any error to my account at the Bank (or other financial institution) I have indicated below. I also authorize said Bank to debit and, if applicable, credit the amount of those entries to my account made payable to the order of **MBA, Inc.**, Scottsdale, Arizona.

I understand and agree that:

- 1) My premium will be drafted on or about the 5th day of each month;
- 2) The Bank's rights with respect to each charge will be the same as if personally executed by me;
- 3) This authorization will remain in effect until I provide written notification to MBA, Inc. that I wish to revoke it;
- 4) MBA, Inc. and my Bank may discontinue this service;
- 5) The presentation of any such debit or draft shall constitute due notice of premiums being due for a policy of insurance on my behalf. I understand that should my Bank dishonor any such debit or draft for any reason, it will be my responsibility to make arrangements with MBA, Inc. for premium payments within the grace period to prevent lapse or possible termination due to non-payment in accordance with the terms of the policy. It is also understood that MBA, Inc. assumes no responsibility for bank charges on these draws; and
- 6) I further agree that my bank shall be under no obligation to furnish me with any special advice or notice of the payment of any such debit, other than my monthly banking statement.

INSURED INFORMATION premium payer

Name of Insured/Employer

Account or PID Number

Month to begin my PAC Service

Email Address

Under the bank draft arrangement, we present a draft to your bank each month for the amount of your premium. The bank pays us, and then lists the draft on your statement, just as it lists your other cancelled checks.

Please take a few minutes to complete the information requested on this form, and return it along with a voided check or a copy of a check on which is printed your account number and bank transit number.

BANK ACCOUNT INFORMATION

Name of Bank or Financial Institution

Branch City State Zip

Name(s) as appears on Bank Account

Checking Account # Bank Transit/Routing #

Signature of Premium Payer
(Must be identical to bank records)

**Seniors Choice Questions?
Please call (888) 538-9333**

