RETIREE HEALTH CARE PLAN ENROLLMENT FORM

Retiree Name			Employee ID #
Address	City	State	Zip Code
Email Address	Home Phone	Birthdate	

Health Plan Enrollment

I wish to enroll in the following coverage:	[ ] Medical Coverage [ ] Prescription Drug Coverage (Include RLH Medicare Script Application) [ ] Dental Coverage **(only available during first 18 months of RHCP enrollment)**	[ ] I wish to waive enrollment at this time because I am currently enrolled in another health plan

Individuals to be Enrolled	Name (Include last name if different from Retiree)	Social Security Number	Relationship	Medicare-Eligible (If not currently eligible, anticipated eligibility date)	Birthdate Month/Day/Year
Retiree			SELF	[ ] Yes [ ] Date: _____	
Spouse			[ ] Husband [ ] Wife	[ ] Yes [ ] Date: _____	
Eligible Dependent Children (See definition of eligible dependents on reverse side of this form)			[ ] Daughter [ ] Son	[ ] Yes [ ] Date: _____	
			[ ] Daughter [ ] Son	[ ] Yes [ ] Date: _____	
			[ ] Daughter [ ] Son	[ ] Yes [ ] Date: _____	
			[ ] Daughter [ ] Son	[ ] Yes [ ] Date: _____	

Certification

- I have reviewed and understand the Plan rules stated on the back of this election form. I certify that the information I have provided on this form is true and correct.
- I understand I may enroll in the Retiree Health Care Plan within one month of my retirement from the University. If I waive coverage at that time, I may only enroll during a future open enrollment period, if any, or within 31 days of the date I lose my other employer group health coverage (for a reason other than non-payment of premiums).
- I acknowledge that additional rules apply to my enrollment in the plan if I am enrolled as the Surviving Spouse and/or Surviving Dependent of a University employee. Information is on the back of this form and in the Plan's Summary Plan Description.
- I acknowledge that if I and/or my enrolled dependents are eligible for Medicare, we must enroll in Medicare Parts A and B and Medicare Part D. I understand that the Retiree Health Care Plan will pay secondary to Medicare, whether or not we are actually enrolled in Medicare.
- I understand that dental coverage is only available during the first 18 months of Retiree Health Care Plan eligibility. If I choose to waive participation now and wish to add dental coverage later, I may enroll during an open enrollment period only for the remainder of the 18-month period. If I enroll, once the 18-month dental benefit period expires, I may enroll in dental coverage through Regence BlueCross BlueShield within 30 days of loss of Retiree Health Care Plan dental coverage.
- I agree to notify the Benefits Department if one of my listed dependents ceases to qualify as an eligible dependent. I understand that my dependent will only be eligible for COBRA coverage for the period remaining if they had elected COBRA coverage instead of enrolling in the Retiree Health Care Plan.
- I hereby authorize billing of premiums as required and acknowledge that coverage will be cancelled if premiums are not paid when due.

Retiree Signature: _____ Date: _____

Benefits Dept Use Only:	Entry Date:	Entered By:		

Statement of Understanding and Agreements

Eligible Dependents

I understand that **eligible dependents** are the person to whom I am legally married or an eligible Domestic Partner and my (or my spouse's or domestic partner's) unmarried children by birth, placement for legal adoption or foster care, or legal (court-appointed) guardianship, who are under age 26 and dependent on me for more than 50% of their support. Coverage may be continued at age 26 under certain circumstances. I agree to notify the Benefits Department if one of my enrolled dependents is no longer an eligible dependent. I understand that I must provide notification within 60 days in order for the dependent to be eligible for COBRA Continuation Coverage. I understand that my dependent will only be eligible for COBRA coverage for the period remaining if they had elected COBRA coverage instead of enrolling in the Retiree Heath Care Plan.

Surviving Spouse and/or Surviving Enrolled Dependent

I understand that if I am enrolled as the Surviving Spouse or Surviving Enrolled Dependent of a deceased University employee, I may only enroll in this Plan if I was enrolled in the University of Utah Employee Health Care Plan on the day immediately preceding the death of the employee. I understand my coverage will terminate on the date I would otherwise lose coverage pursuant to the terms of the Plan (e.g., nonpayment or fraud). I understand that as a Surviving Spouse I may only enroll children enrolled in the plan on the day before the death of the employee and any children of the deceased University employee born to me after the death of the employee. I may not enroll any other dependents. If I enroll in the Plan and later terminate participation in the Plan, I understand that I will only be eligible to reenroll in the future if I was enrolled in employer group coverage or a Medicare Advantage or Medicare Supplement plan.

Social Security Numbers are Required for All Dependents

Beginning January 1, 2009, Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 requires all health plans in the United States to report group and member information to the Centers for Medicare and Medicaid Services (CMS). The new law will help CMS accurately coordinate Medicare and group benefits for people who have both types of coverage. Since individuals under age 65 who have end stage renal disease or other disabilities are eligible for Medicare, we need to provide information, including social security numbers, for all enrolled members.

Understandings and Agreements

In addition to the understandings and agreements in the Certification section on the first page of this form, I also understand and agree to the following:

- To the extent authorized under applicable law, I accept Binding Arbitration as the method of resolving any disputes arising between me or the covered family member and the Plan, or a participating physician, concerning the applicability of benefits payable under the Subscriber Agreement.
- I understand that to continue my enrollment in the Health Care Plan, I must make timely payments of the full amount due each month.
- To the minimum extent necessary to implement coverage, and in accordance with rules set forth in the HIPAA Privacy Regulations, I authorize Regence BlueCross BlueShield of Utah, Regence Pharmacy Services, and Regence Medicare Script to request any medical, health, employment, and/or insurance information necessary to complete my enrollment and process my claims.
- I certify that all information on this form is true and correct and acknowledge that the University may take corrective action against Participants who (a) enroll an individual in the Health Care Plan that they know or should know is ineligible and/or (b) file claims (either directly or indirectly through a health care provider) for an individual that they know or should know is ineligible for coverage under the Plan. Corrective action includes legal action for reimbursement of all claims and cancellation of coverage without the right to elect COBRA continuation coverage.
- I understand that the University intends to continue the Plan indefinitely; however, it reserves the right to amend, suspend or discontinue it at any time.

University Human Resource Management

250 East 200 South, Suite 125, Salt Lake City, Utah 84111

Hours: 8:00 am - 5:00 pm, Monday-Friday

Phone: (801) 581-7447

Email: benefits@utah.edu / **Web:** www.hr.utah.edu/benefits

Summary Plan Descriptions are available at www.hr.utah.edu/ben/retirees