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 and Prescription Drug Coverage - Medicare-eligible individuals must each complete RLH MedicareScript Application [ ] Medical Only (Medicare-eligible individuals only—must enroll in separate Part D coverage) [ ] Dental Coverage (available only during first 18 months of Retiree HCP eligibility)

Individuals to be Enrolled	Name (Include last name if different from Retiree)	Social Security Number	Relationship	Medicare-eligible?	Birthdate Month/Day/Year
Retiree			SELF	[ ] Yes [ ] No	
Spouse			[ ] Husband [ ] Wife	[ ] Yes [ ] No	
Eligible Dependent Children (See definition of eligible dependents on reverse side of this form)			[ ] Daughter [ ] Son	[ ] Yes [ ] No	
			[ ] Daughter [ ] Son	[ ] Yes [ ] No	
			[ ] Daughter [ ] Son	[ ] Yes [ ] No	
			[ ] Daughter [ ] Son	[ ] Yes [ ] No	

Certification

I have read and I agree to the conditions contained on the back of this form.

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 in the plan at a later date if I have other employer group health coverage at the time I waive this coverage. If this is the case, I may enroll in the Retiree Health Care Plan within 31 days of the date I lose my other employer group health coverage. I understand that if I elect Medicare Supplement Plan H coverage, I may not later enroll in the other option under the Retiree Health Care Plan. I understand that if I enroll and later drop coverage, I may not reenroll in the Retiree Health Care Plan.

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 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 through the University Benefits Department. 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 be allowed to enroll 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 Heath Care Plan.

I hereby authorize billing of premiums as required and acknowledge that coverage may be cancelled if premiums are not paid when due.

I certify the information I have provided on all parts of this form is true and correct. I understand that if I knowingly file a statement of claim for an individual who does not qualify as an eligible dependent or otherwise containing any misrepresentation or any false, incomplete, or misleading information, my coverage may be cancelled without the right to elect COBRA, and I may be guilty of a criminal act punishable under law and subject to civil penalties.

Retiree Signature: ______________________________________ Date: ____________________________

Benefits Dept Use Only:	Entry Date:	Entered By:	QC By:	QC Date:

Statement of Understanding and Agreements

Eligible Dependents

I understand that **eligible dependents** are the person to whom I am legally married and my (or my spouse'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. 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 become eligible for another group plan (e.g., through employment, marriage, etc.) or 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 a child of the deceased University employee born to me after the death of the employee. I may not enroll any other dependents.

Preexisting Condition Waiting Period

To the extent allowed under federal law, I understand the health care plan does not cover treatment of preexisting conditions for newly enrolled participants during the first 6 months following enrollment or, for late enrollees, during the first 18 months following enrollment; unless this preexisting condition waiting period is reduced by a period(s) of prior creditable coverage as defined by HIPAA. I am responsible for submitting a certificate(s) or other evidence of prior creditable coverage. A Preexisting Condition is defined as a physical or mental condition, except for pregnancy, whether diagnosed or misdiagnosed, which within the six-month period before your Enrollment Date (defined in the Plan):

- You incurred expense, received medical treatment, services or advice, underwent diagnostic procedures, took prescribed drugs or medicine, or consulted a physician or other licensed medical professional; or
- Was discovered or suspected as a result of any medical examination, including a routine medical examination.

The Plan will not impose a waiting period for a preexisting condition for a newborn child, an adopted child, or a child placed with me for adoption if I complete the paperwork to add the child within 3 months of the birth, adoption, or placement, respectively.

Social Security Numbers are Now 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 certain 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 coverages. 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.

Agreement

I hereby make application on behalf of myself and listed eligible family dependents for membership in the University of Utah Retiree Health Care Plan as indicated hereon and agree to the terms and conditions in the Master Policy. I understand that if I am eligible and this enrollment form is completed and provided to the University Benefits Department timely, my benefits will begin on my effective date as determined by the enrollment rules of the Plan.

To the minimum extent necessary to implement coverage and to provide coverage benefits, and in accordance with rules set forth in the HIPAA Privacy Regulations, I authorize Regence BlueCross/BlueShield of Utah, Blomquist Hale Consulting, UNI BHN, and CVS Caremark to request and use any medical, health, employment, and/or insurance information necessary to complete my enrollment, provide coverage benefits, and administer my coverage benefits. I authorize pretax payroll deduction of contributions as required through the provisions of IRC Section 125 Flexible Benefits. I agree to abide by the Plan's enrollment provisions. I authorize the University to act as my agent in all matters of administration of the group program, and acknowledge that the University is in no way acting as agent for those companies administering the Plan. To the extent authorized under applicable law, I accept Binding Arbitration as the method of resolving any disputes arising between me or my covered family member and the Plan, or a participating physician, concerning the applicability of benefits payable under the Plan. I understand that the University intends to continue the Plan(s) indefinitely; however, it reserves the right to amend, suspend or discontinue the Plan(s) at any time.

I certify that all information on this form is true and correct and acknowledge that my coverage is subject to cancellation if any completed information is found to be false or incorrect and I will be responsible for reimbursement to the Plan for any claims paid in error.

For detailed plan information, please refer to the Plan's Summary Plan Description.
Summary Plan Descriptions are available on the internet at www.hr.utah.edu/ben/retirees or in the Benefits Department located at 420 Wakara Way, Ste. #105, Salt Lake City, UT 84108.
Phone: 801-581-7447, Fax: 801-585-7375, e-mail: benefits@hr.utah.edu

RETIREE HEALTH CARE PLAN MONTHLY PREMIUMS
January 1, 2012 through December 31, 2012

	Medical and Prescription Drug Coverage	Medical Only	Medical, RX and Dental
Single			
Not Medicare Eligible	$808.32	N/A	$849.52
Medicare Eligible	$405.02	$227.02	$446.22
Two-party			
Not Medicare Eligible	$1,229.31	N/A	$1,311.91
1 Medicare Eligible	$1,172.54	$994.54	$1,255.14
Both Medicare Eligible	$769.25	$413.25	$851.85
Family			
Not Medicare Eligible	$1,229.31	N/A	$1,340.71
One or More Medicare Eligible	$1,172.54	$994.54	$1,283.94

RLH MedicareScript Part D Prescription Drug Coverage Only	$178.00

	Single	Two-Party	Family
Dental Only	$41.20	$82.60	$111.40