Group Benefits from The Hartford

HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY

One Hartford Plaza
Hartford, CT 06155
(A stock insurance company)

The Hartford® is The Hartford Financial Services Group, Inc. and its subsidiaries.

GROUP RETIREE HEALTH INSURANCE – GRIP (THE HARTFORD'S GROUP RETIREE INSURANCE PLAN®) ENROLLMENT FORM FOR INITIAL ENROLLMENT AND SUBSEQUENT CHANGES

Participating Employer: ELON UNIVERSITY **Policy Number(s): AGP-007040**

Please Print clearly in ink or type:		
Retiree's First Name:	Middle:	Last:
Street:		
City:	State:	ZIP Code:
Phone Number: ( )	Medicare Number	
Email Address:		
Gender: ☐ Male ☐ Female	Date of Birth:	Social Security #
Date of Retirement:	Have you enrolled in Medicare Part B? ☐ Yes ☐ No	
If no, when do you intend to enroll?		

Spouse's Name (Only if enrolling):

First:	Middle:	Last:
Gender: ☐ Male ☐ Female	Date of Birth:	
Social Security #	Medicare Number	
Date of Retirement:	Has your spouse enrolled in Medicare Part B? ☐ Yes ☐ No	
If no, when does he/she intend to enroll?		

To the best of your knowledge:

1. Do you or your spouse, if enrolling, have any other health insurance including an employer health plan?

Retiree: ☐ Yes ☐ No Spouse: ☐ Yes ☐ No

If so, please provide the information requested below:

Covered Person	Company Name	Policy Number	Kind of Policy	Effective Date	Expiration Date

Form PA-9627

2. If the answer to question 1 is yes, do you or your spouse, if enrolling intend to replace these medical or health policies with this policy or certificate?

Retiree: ☐ Yes ☐ No	Spouse: ☐ Yes ☐ No

If yes, for what reason are you (or your spouse, if enrolling) replacing the coverage?

☐ Additional Benefits ☐ Fewer benefits and lower premiums
☐ Integration with Medicare ☐ No change in benefits, but lower premiums
☐ Other (please specify):

3. Are you covered by Medicaid?

Retiree: ☐ Yes ☐ No	Spouse: ☐ Yes ☐ No

Check Desired Coverage

	Effective Date	Plan 1	n/a
Retiree:		☐	☐
Spouse:		☐	☐

Complete the 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

Confirmation

I acknowledge that I have been given the opportunity to enroll in the insurance offered by the Policyholder. I understand and agree that if I decline insurance now, I may not be able to enroll in the future.

I understand and agree that insurance will go into effect and remain in effect only in accordance with the provisions, terms and conditions of the insurance policy. I understand and agree that only the insurance policy issued to the Policyholder can fully describe the provisions, terms, conditions, limitations and exclusions of my insurance. In the event of any difference between the enrollment form and the insurance policy, I agree to be bound by the insurance policy.

Fraud Notice(s)

For Residents of Florida:

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

For Residents of Louisiana:

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.

For Residents of Maryland:

Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

For Residents of New York:

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

For Residents of Virginia:

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits

Retiree Signature:	Date:
Spouse Signature (if enrolling):	**Date:**

Form PA-9627

Supplemental Health Enrollment Form

MEDICARE PRESCRIPTION DRUG PLAN INDIVIDUAL ENROLLMENT FORM
ELON UNIVERSITY SPONSORED GROUP PLAN

To enroll in Express Scripts Medicare® (PDP)
please provide the following information:

Desired Effective Date: _____

LAST Name:	FIRST Name:	MIDDLE Initial:	Mr Mrs. Ms. .
Birth Date: (__ __/__ __/__ __ __ __) (M M / D D / Y Y Y Y)	Sex: M F	Home Phone Number: ( )	
Permanent Residence Street Address:			
City:	State:	ZIP Code:	
Mailing Address (only if different from your Permanent Residence Address): Street Address:	City:	State:	ZIP Code:
Emergency Contact: [Optional]			
Phone Number: [Optional]_____	**Relationship to You** [Optional] _____		
E-mail Address: [Optional]			

Please Provide Your Medicare Insurance Information

Please take out your Medicare Card to complete this section. • Please fill in these blanks so they match your red, white and blue Medicare card. - OR - • Attach a copy of your Medicare card or your letter from the Social Security Administration or Railroad Retirement Board. You must have Medicare Part A or Part B (or both) to join a Medicare prescription drug plan.	Name: Medicare Number _____-_____- _____ OR Medicare Claim Number — — — -_____-_____- _____ Is Entitled To / Effective Date **HOSPITAL (Part A)** **MEDICAL (Part B)** _____

2018 BXMA (02/18)

Email completed enrollment form to **memelig@bensitar.com** or mail to **Benistar Admin Services**
10 Tower Lane, Suite 100
Avon, CT 06001

Supplemental Health Enrollment Form

Important Information About Your Medicare Part D Prescription Drug Plan

Express Scripts Medicare® (PDP) is offered by Medco Containment Life Insurance Company, which contracts with the Federal government. This coverage is Medicare Part D coverage and is in addition to your coverage under Medicare Parts A and B. You must keep your Medicare Parts A and/or B coverage in order to qualify for this plan. You must inform your former employer of any other prescription drug coverage you may have.

Enrollment Requirements
You can be in only one Medicare prescription drug plan at a time. If you are currently in a Medicare prescription drug plan, a Medicare Advantage Plan with prescription drug coverage, or an individual Medicare Advantage Plan, your enrollment in Express Scripts Medicare may end that enrollment.

You must live within the 50 U.S. states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, Guam, the Northern Mariana Islands or American Samoa, and be a U.S. citizen or lawfully present in the United States to participate in this plan. It is your responsibility to inform your former employer of any address changes.

You can join a new Medicare prescription drug plan or Medicare health plan from October 15 to December 7. Except in special cases, you cannot join a new plan at any other time of the year. If you leave this plan and don't have or get other Medicare prescription drug coverage or creditable coverage (as good as Medicare's), you may be required to pay a late enrollment penalty (LEP) if you go 63 days or more without Medicare Part D coverage or other creditable prescription drug coverage.

Some people may have to pay an extra premium amount because of their yearly income. If you have to pay an extra amount, the Social Security Administration – not your Medicare plan – will send you a letter telling you what that extra amount will be and how to pay it. If you have any questions about this extra amount, contact the Social Security Administration at 1.800.772.1213. TTY users call 1.800.325.0778.

Medicare beneficiaries with low or limited income and resources may qualify for Extra Help. If you qualify, your Medicare prescription drug plan costs will be less. Once you are enrolled in this drug plan, Medicare will tell the plan how much assistance you will receive and Express Scripts will send you information on the amount you will pay. If you are not currently receiving Extra Help, you can contact 1.800.MEDICARE (1.800.633.4227) to see if you might qualify. TTY users call 1.877.486.2048.

Once you are a member of this plan, you have the right to file a grievance or appeal plan decisions about payment or services if you disagree. Read your *Evidence of Coverage* to know which rules you must follow to receive coverage with this Medicare prescription drug plan.

This information is not a complete description of benefits. Contact Express Scripts Medicare for more information. Limitations, copayments and restrictions may apply. Benefits, premium (if applicable) and/or copayments/coinsurance may change on January 1 of each year. The formulary and/or pharmacy network may change at any time. You will receive notice when necessary.

Release of Information
By joining this Medicare prescription drug plan, I acknowledge that Express Scripts Medicare can release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that Express Scripts Medicare can release my information, including my prescription drug event data, to Medicare, who may release it for research and other purposes that follow all applicable Federal statutes and regulations.

Signature:	**Today's Date:**

Express Scripts Medicare (PDP) is a prescription drug plan with a Medicare contract.
Enrollment in Express Scripts Medicare depends on contract renewal.