

# BENEFITS ELECTION FORM FOR RETIREES, PARTICIPANTS ON LONG TERM DISABILITY (LTD) AND ELIGIBLE FAMILY MEMBERS



## 1. RETIREE OR LTD INFORMATION

Name	Address	Life #
Are you a surviving spouse? <input type="checkbox"/> Yes <input type="checkbox"/> No		Phone

## 2. MEDICAL INSURANCE

Indicate your name and the names of your eligible family members to be covered. Indicate <b>separately</b> in each section below the names of individuals who are eligible for Medicare and those who are not eligible for Medicare on the effective date of the coverage election.	Effective Date
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### 2A. ARE YOU OR ANY OF YOUR FAMILY MEMBERS ELIGIBLE FOR MEDICARE? Yes No If you answered "no" skip to section 2B

BSA partners with SelectQuote Benefit Solutions, a private healthcare exchange, to assist individuals who are eligible for Medicare in selecting and enrolling in a healthcare plan for medical and prescription drug coverage. Call SelectQuote at 1-866-479-8317 to sign up for a new healthcare plan or change plans. Indicate below the information for the individuals who are eligible for Medicare.

Indicate name(s) of Medicare-eligible individual(s) to be covered	Relationship	Social Security #	Date of Birth	Gender	Add a Dependent	Cancel Coverage	Suspend Coverage
				<input type="checkbox"/> M <input type="checkbox"/> F			
				<input type="checkbox"/> M <input type="checkbox"/> F			
				<input type="checkbox"/> M <input type="checkbox"/> F			

### 2B. ARE YOU OR ANY OF YOUR FAMILY MEMBERS NOT ELIGIBLE FOR MEDICARE? Yes No **SELECT AETNA PLAN:** Plan 1 Plan 2 Plan 3

Indicate name(s) of Non-Medicare-eligible individual(s) to be covered	Relationship	Social Security #	Date of Birth	Gender	Add a Dependent	Cancel Coverage	Suspend Coverage
				<input type="checkbox"/> M <input type="checkbox"/> F			
				<input type="checkbox"/> M <input type="checkbox"/> F			
				<input type="checkbox"/> M <input type="checkbox"/> F			

## 3. DENTAL INSURANCE Dental plans are not available to retirees unless elected under COBRA immediately following retirement and for a maximum period of 18-months

Dental Plan <input type="checkbox"/> DMO <input type="checkbox"/> PPO <input type="checkbox"/> INDEMNITY	Indicate your coverage. <input type="checkbox"/> 1 Person <input type="checkbox"/> 2 People <input type="checkbox"/> 3 or more People	Effective Date
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Indicate name(s) of individual(s) to be covered	Relationship	Social Security #	Date of Birth	Gender	Add a Dependent	Cancel Coverage	Suspend Coverage
				<input type="checkbox"/> M <input type="checkbox"/> F			
				<input type="checkbox"/> M <input type="checkbox"/> F			
				<input type="checkbox"/> M <input type="checkbox"/> F			

## 4. AUTHORIZATION

I hereby authorize the elections indicated above and agree to pay the required premiums for the coverage I have elected. I understand that if any of the individuals I have indicated above under Section 2A are eligible for Medicare, it is my responsibility to contact SelectQuote who will assist those individuals in selecting and enrolling in a healthcare plan.

Signature \_\_\_\_\_ Date \_\_\_\_\_