Brookhaven National Laboratory

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? ☐ Yes ☐ No		Phone

2. MEDICAL INSURANCE

Indicate your name and the names of your eligible family members to be covered. Indicate **separately** 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 **1/1/2022**

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
			I I	☐ M ☐ F			
			I I	☐ M ☐ F			
			I I	☐ M ☐ 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 ◯ Plan 4

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
			I I	☐ M ☐ F			
			I I	☐ M ☐ F			
			I I	☐ M ☐ 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

Effective Date **1/1/2022**

Dental Plan ◯ DMO ◯ PPO ◯ INDEMNITY

Indicate your coverage. ◯ 1 Person ◯ 2 People ◯ 3 or more People

Indicate name(s) of **individual(s)** to be covered	Relationship	Social Security #	Date of Birth	Gender	Add a Dependent	Cancel Coverage
			I I	☐ M ☐ F		
			I I	☐ M ☐ F		
			I I	☐ M ☐ F		

4. VISION INSURANCE

Vision plans are not available to retirees unless elected under COBRA immediately following retirement and for a maximum period of 18 months

Effective Date **1/1/2022**

Indicate your coverage. ◯ 1 Person ◯ 2 People ◯ 3 or more People

Indicate name(s) of **individual(s)** to be covered	Relationship	Social Security #	Date of Birth	Gender	Add a Dependent	Cancel Coverage
			I I	☐ M ☐ F		
			I I	☐ M ☐ F		
			I I	☐ M ☐ F		

5. FOR QUALIFYING EVENTS *For Benefits Office Use Only*

If you are making these elections due to a Qualifying Event, indicate the following information.

◯ Add dependent(s) ◯ Elect Coverage
◯ Delete dependent(s) ◯ Terminate Coverage

Notes: _____

Indicate the Qualifying Event.

◯ Marriage
◯ Birth, adoption, or placement for adoption
◯ Change in work schedule
◯ Change in dependent eligibility
◯ Other: _____
◯ Divorce or legal separation
◯ Death of a dependent
◯ Change in employment status
◯ Change in place of residence or worksite

Each Qualifying Event will be reviewed on an individual basis to determine eligibility for the requested change. Supporting documentation must be provided.

6. 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_____