BENEFITS ENROLLMENT FORM

PUBLIC SCHOOL RETIREMENT SYSTEM OF THE CITY OF ST. LOUIS

SECTION 1 – PLAN SELECTION, REASON & EFFECTIVE DATE

Reason for Enrollment/Change: ☐ Other_____

☐ New Retiree ☐ Involuntary Coverage Loss ☐ OE Plan Change ☐ Medicare-Eligibility

Coverage Effective Date

UnitedHealthcare Group Medical Plans	Delta Dental of Missouri Networks: PPO & Premier	EyeMed Network: "InSight"	NEW VOLUNTARY BENEFIT OFFERINGS	
			MetLife	Allstate
☐ Base Plan ☐ Buy-Up Plan Medicare Advantage ☐ Low Plan ☐ High Plan	☐ Low Plan ☐ High Plan *If using PPO Network Providers, enroll in the Low Plan*	☐ Vision	☐ Prepaid Legal Coverage cannot be cancelled until member has been enrolled for at least 12 months.	☐ Identity Theft
☐ Retiree Only ☐ Retiree + Spouse* ☐ Retiree, Spouse + Child(ren)* ☐ Retiree + Child(ren)*	☐ Retiree Only ☐ Retiree + 1 Dependent* ☐ Retiree + Family	☐ Retiree Only ☐ Retiree + 1 Dependent* ☐ Retiree + Family	☐ Retiree + Family	☐ Retiree Only ☐ Retiree + Family

***If enrolling dependents in medical, dental and/or vision coverages, you must complete SECTION 4**

☐ Yes ☐ No	Do you have other prescription drug coverage (including private insurance, workers' compensation, VA benefits or through the State Pharmaceutical Assistance Program? If yes, please complete the following: Name of other coverage: _____ ID #: _____ Group #: _____

SECTION 2 – RETIREE PERSONAL INFORMATION

First Name - M.I. - Last Name - Suffix (Jr., Sr.)	PSRS Member ID *(PSRS to provide)*	Date of Birth

Last 4 digits of SSN	Gender		Marital Status				
	☐ F	☐ M	☐ Single	☐ Married	☐ Separated	☐ Divorced	☐ Widowed

Permanent Street Address (no P.O. Boxes)	City	State	Zip Code
Mailing Address (P.O. Boxes)	City	State	Zip Code
Home Phone (required, if applicable)	Cell Phone (required, if applicable)	Email	

SECTION 3 – RETIREE MEDICARE INFORMATION

(Complete this section ONLY if you are Medicare-eligible AND are enrolling in OR changing medical plans)

Medicare Claim Number	Part A Effective Date	Part B Effective Date

☐ Yes	☐ No	Have you had continuous creditable prescription coverage since becoming Medicare-eligible?
☐ Yes	☐ No	Are you a resident of a long-term care facility?
☐ Yes	☐ No	Do you have End State Renal Disease (ESRD)?
☐ Yes	☐ No	Did you become eligible for Medicare because you were diagnosed with End Stage Renal Disease *and* has it been less than 30 months since you became eligible?
☐ Yes	☐ No	Are you enrolled in your State Medicaid Program? If yes, provide your Medicaid number:

Medicare Election Period		
☐ Initial Enrollment	☐ Annual (Open Enrollment)	☐ Special Enrollment

SECTION 4 – DEPENDENTS' PERSONAL INFORMATION

Note: Per PSRS Group Enrollment Policy, all dependents must be enrolled in the same plan(s) as the Retiree
Dependent enrollment in the Identify Theft Protection and Prepaid Legal is handled directly with the Vendor.

DEPENDENT #1

First Name / M.I. / Last Name & Suffix (Jr., Sr.)	Gender	Relation	Date of Birth	SSN
	☐ F ☐ M	☐ Spouse		
Indicate the coverages enrolling in:	☐ **Medical**		☐ **Dental**	☐ **Vision**

DEPENDENT #2

First Name / M.I. / Last Name & Suffix (Jr., Sr.)	Gender	Relation	Date of Birth	SSN
	☐ F ☐ M	☐ Child		
Indicate the coverages enrolling in:	☐ **Medical**		☐ **Dental**	☐ **Vision**

DEPENDENT #3

First Name / M.I. / Last Name & Suffix (Jr., Sr.)	Gender	Relation	Date of Birth	SSN
	☐ F ☐ M	☐ Child		
Indicate the coverages enrolling in:	☐ **Medical**		☐ **Dental**	☐ **Vision**

Complete this section if Medicare-eligible AND if enrolling in/changing medical plans	**DEPENDENT #1**	**DEPENDENT #2**	**DEPENDENT #3**
Medicare Claim Number			
Part A Effective Date			
Part B Effective Date			
Have you had continuous creditable prescription coverage since becoming Medicare-eligible?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Are you a resident of a long-term care facility?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Do you have End State Renal Disease (ESRD)?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Did you become eligible for Medicare because you were diagnosed with End Stage Renal Disease *and* has it been less than 30 months since you became eligible?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Are you enrolled in your State Medicaid Program? If yes, provide your Medicaid number	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Do you have other prescription drug coverage (including private insurance, workers' compensation, VA benefits or through the State Pharmaceutical Assistance Program?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
If you have other prescription drug coverage, please provide: 1. Name of other coverage 2. Member ID # 3. Group #			
Medicare Election Period	☐ Initial Enrollment ☐ Annual (Open Enrollment) ☐ Special Enrollment	☐ Initial Enrollment ☐ Annual (Open Enrollment) ☐ Special Enrollment	☐ Initial Enrollment ☐ Annual (Open Enrollment) ☐ Special Enrollment

AGREEMENT: Please read the following carefully.

1. I apply for membership in UnitedHealthcare for myself and for any eligible dependents listed. I authorize PSRSSTL to make deductions for the premiums.
2. I and my eligible dependents shall abide by the provisions of coverage in the UnitedHealthcare Enrollment agreement, Certificate of Coverage and Benefit Riders under which we are enrolled.
3. By signing this form, I authorize the Public School Retirement System and any physician, hospital, medical group or other facility providing me care, treatment or consultation, to disclose to UnitedHealthcare, or receive from UnitedHealthcare, any medical or claim information pertaining to the persons identified in this enrollment form receiving coverage under this plan, as may be necessary to enable UnitedHealthcare to make coverage determinations, pay claims or otherwise administer plan programs, including without limitation, credentialing of physicians and as applicable, other providers, all of which shall be conducted in accordance with state and federal confidentiality laws. UnitedHealthcare will not disclose any information pertaining to HIV/AIDS or chemical dependency/substance abuse except as specifically permitted by applicable law.
4. I understand and agree no benefits shall take effect until this application is approved by UnitedHealthcare and, if applicable, Medicare.
5. I understand that my membership may be cancelled for one or both of the following reasons: 1) failure to pay the amount due under the UnitedHealthcare Enrollment Agreement or Certificate of Coverage, for which I am legally responsible, or (2) fraud or material misrepresentation in enrollment or in the use of services or facilities.
6. I understand that it is my responsibility to report to the Public School Retirement System any change in the eligibility of myself or my dependents.

By signing this form, I certify ALL information given is true and accurate.

By enrolling in one of the UnitedHealthcare® Group Medicare Advantage PPO Plans, I agree to the following: **This is a Medicare Advantage plan and has a contract with the federal government. This is not a Medicare Supplement plan.** I need to keep my Medicare Part A and Part B, and continue to pay my Medicare Part B and, if applicable, Part A premiums, if they are not paid for by Medicaid or a third party. **I can only have one Medicare Advantage or Prescription Drug plan at a time.**

- Enrolling in this plan will automatically dis-enroll me from any other Medicare health plan. If I dis-enroll from this plan, I will be automatically transferred to Original Medicare. If I enroll in a different Medicare Advantage plan or Medicare Part D Prescription Drug Plan, I will be automatically disenrolled from this plan.
- If I have prescription drug coverage or if I get prescription drug coverage from somewhere other than this plan, I will inform UnitedHealthcare®.
- Enrollment in this plan is for the entire plan year. I may leave this plan only at certain times of the year or under special conditions.

If I do not have prescription drug coverage, I may have to pay a late enrollment penalty. This would apply if I did not sign up for and maintain creditable prescription drug coverage when I first became eligible for Medicare. If I get a late enrollment penalty, I will receive a letter making me aware of the penalty and what the next steps are. **The service area includes the 50 United States, the District of Columbia and all U.S. territories.** I may not be covered while out of the country, except for limited coverage near the U.S. border. However, under this plan, when I am outside of the U.S., I am covered for emergency or urgently needed care. **I will get a Plan Details book that includes an Evidence of Coverage (EOC).**

- The EOC will have more information about services covered by this plan. If a service is not listed, it will not be paid for by Medicare or this plan without authorization.
- I have the right to appeal plan decisions about payment or services if I do not agree.

My information will be released to Medicare and other plans, only as necessary, for treatment, payment and health care operations. Medicare may also release my information for research and other purposes that follow all applicable Federal statutes and regulations.

The Formulary, pharmacy network, and/or provider network may change at any time. You will receive notice when necessary.

Plans are insured through UnitedHealthcare® Insurance Company or one of its affiliated companies, a Medicare Advantage organization with a Medicare contract and a Medicare-approved Part D sponsor. Enrollment in the plan depends on the plan's contract renewal with Medicare.

You must continue to pay your Medicare Part B premium.

Out-of-network/non-contracted providers are under no obligation to treat UnitedHealthcare® members, except in emergency situations. Please call our customer service number (1-844-876-6160) or see your Evidence of Coverage for more information.

By enrolling in the Delta Dental Plan, I understand: 1) that there may be instances where treatment decisions made by my dentist or me or dental expenses which I have incurred may not be covered by my dental plan; 2) that information collected in connection with administration of the benefit plan may be used to bring to my attention health products or services that might be valuable to me and otherwise as permitted by law; 3) that you may combine that information with other information so that it is no longer individually identifiable and use it for commercial and other purposes. Any person who knowingly and with intent to injure, defraud or deceive any insurer, files a statement or an application containing any false, incomplete or misleading information is guilt of a felony of the third degree. The Delta Dental Certificate provides dental benefits only. Review the Certificate of Coverage carefully.

By signing this form, I certify ALL information given is complete, true and accurate.

Pension Deduction Authorization: By signing this application, member authorizes the Public School Retirement System to withhold insurance premiums for such coverage from member's monthly pension check. Monthly premiums for the available plans are determined annually by each respective insurance company. This authorization may not be withdrawn unless member cancels the coverage for which the premium deductions are authorized. By signing this application, member understands that some of the insurance companies impose restrictions on cancellations. Member also understands that he/she must notify the Public School Retirement System in writing in order to cancel coverage and withdraw this deduction authorization.

RETIREE SIGNATURE (**Required**):	SIGNATURE DATE:

DEPENDENT SIGNATURE REQUIRED WHEN ENROLLING DEPENDENT IN A MEDICARE ADVANTAGE PLAN

DEPENDENT #1 SIGNATURE:	SIGNATURE DATE:
DEPENDENT #2 SIGNATURE:	SIGNATURE DATE:
DEPENDENT #3 SIGNATURE:	SIGNATURE DATE:

EMAIL:	*monica.brewer@psrsstl.org* *Email as a separately attached file* (do not insert picture)
PHONE:	*314-534-7444 Ext. 3011*
FAX:	*314-533-0531*
MAIL:	*Public School Retirement System* *3641 Olive Street, Suite 300* *St. Louis, MO 63108* *Attention: Monica Brewer* *(If sending by mail, please do so ASAP to avoid delays)*