Northwest Retiree Benefit Trust
2024 Benefit Change Form
Florida Residents Only

If you are **not** making any plan changes for 2024, you do **not** need to complete or return this form. You will automatically be re-enrolled in your current options.

To make changes in your 2024 plans, please use ink to complete the information below. Check the appropriate boxes for your new coverage elections, sign where indicated, and return this form.

MEDICAL PLAN OPTION RATES - *IMPORTANT: If electing Medical coverage for the first time or changing plans, please fill out The Hartford enrollment form following this election form as well. This is required by The Hartford.*

☐ I would like to waive Medical coverage.

Plan Options	Election Options - *check off both Retiree and Spouse coverage if electing both*	
Premium Plan	❑Retiree Coverage Age: 65-69 $129.94 Age: 70-74 $157.13 Age: 75-79 $186.77 Age: 80-84 $217.73 Age: 85-89 $238.67 Age: 90+ $250.23	❑Spouse or Surviving Spouse Coverage Age: 65-69 $129.94 Age: 70-74 $157.13 Age: 75-79 $186.77 Age: 80-84 $217.73 Age: 85-89 $238.67 Age: 90+ $250.23
Value Plan	❑Retiree Coverage Age: 65-69 $113.38 Age: 70-74 $137.57 Age: 75-79 $164.49 Age: 80-84 $193.41 Age: 85-89 $214.06 Age: 90+ $226.79	❑Spouse or Surviving Spouse Coverage Age: 65-69 $113.38 Age: 70-74 $137.57 Age: 75-79 $164.49 Age: 80-84 $193.41 Age: 85-89 $214.06 Age: 90+ $226.79

PRESCRIPTION DRUG COVERAGE – *coverage through Express* Scripts Medicare™. *Enrollees in Prescription Drug Coverage must continue to pay their Medicare Part B premium.*

☐ I would like to waive Prescription Drug coverage.

Choice Plan	❑Retiree Only Coverage	$149.35
	❑Spouse Only or Surviving Spouse Only Coverage	$149.35
	❑Retiree & Spouse Coverage	$298.70

DENTAL PLAN CHANGES – *coverage through MetLife Dental PPO*		
☐ I would like to waive Dental coverage.		
Dental Plan WITH Medical Coverage	❑ Retiree Only ❑ Spouse Only or Surviving Spouse Only ❑ Retiree & Spouse	$43.94 $43.94 $89.26
Dental Plan WITHOUT Medical Coverage	❑ Retiree Only ❑ Spouse Only or Surviving Spouse Only ❑ Retiree & Spouse	$46.94 $46.94 $92.26

VISION PLAN OPTIONS – *coverage through Superior Vision. You must be enrolled in the medical plan to elect coverage.*		
☐ I would like to waive Vision coverage.		
Vision Plan	❑Retiree Only Coverage ❑Spouse Only or Surviving Spouse Only Coverage ❑Retiree & Spouse Coverage	$6.91 $6.91 $13.27

Note: There is a $1.00 VEBA Trust Fee, $1.25 QualityCare Connect and a $2.72 Silver&Fit® fee per person in addition to the rates shown above.

Complete the following information only if you or your Spouse do not elect Medical coverage. Otherwise, complete The Hartford enrollment form immediately following.

Retiree's Name: _____
First Middle Last

Retiree's Street Address: _____

Retiree's City, State, Zip: _____

Retiree Date of Birth: ___/___/___ **Retiree SSN:** ___-___-___ **Retiree Retirement Date:**___/___/____

Gender: ❑ Male ❑ Female **Email:** _____

Retiree Medicare #: _____ (Exactly as it appears on your Medicare card)

Are you enrolled in Medicare Part B? ❑ Yes ❑ No (Must have Medicare Part B to be eligible for Medical Plan Option)

Spouse's Name: _____
First Middle Last

Spouse's Street Address: _____

Spouse's City, State, Zip: _____

Spouse Date of Birth: __/___/_____ **Spouse SSN:** ___-___-____

Spouse Medicare #: _____ **Spouse Retirement Date:**___/___/____
(Exactly as it appears on your Medicare card)

Is your Spouse enrolled in Medicare Part B? ❑ Yes ❑ No (Must have Medicare Part B to be eligible for Medical Plan Option)

Please answer the following:

1. Do you have any current other health insurance, including an employer or union health plan?
   Retiree: ❑ Yes ❑ No Spouse: ❑ Yes ❑ No
2. If YES, with which company or union? Please indicate below:

Person Covered	Company Name	Policy #	Type of Policy	Effective Date	Expiration Date

3. If the answer to question 1 is YES, do you intend to replace these Medicare Supplement or medical policies with this policy or certificate? ❑ Yes ❑ No

Note: If the answer to question 2 is NO and you intend to continue coverage in another Medicare Supplement or employer/union group health plan, please be aware this Group Retiree Insurance Plan does not coordinate benefits with any other coverage.

4. Are you covered by Medicaid? (This is different than Medicare.) ❑ Yes ❑ No

5. Do you have any other prescription drug coverage including State Pharmaceutical Assistance Program? ❑ Yes ❑ No

6. If YES, please list other coverage and your identification number(s):

Name of Coverage	ID # for Coverage	Group # for Coverage

Please sign below. You must sign for your requested changes to take effect.

I understand that changes or additions I make on this form will take effect January 1, 2024.

X _____ **X** _____

Retiree Signature **Date Signed**

Retiree email:_____

X _____ **X** _____

Spouse/Surviving Spouse Signature (if enrolling) **Date Signed**

Spouse/Surviving Spouse email:_____

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If you have any questions or would like to enroll via the telephone, please contact the Northwest Retiree Benefit Trust Service Center at 1-844-413-2843. Representatives are available Monday through Friday from 8:00 a.m. to 5:00 p.m. (Central time).

If you have made a change in coverage, return the entire form to:
NORTHWEST RETIREE BENEFIT TRUST
Administered by Gilsbar, LLC
P. O. Box 1590; Covington, LA 70434
Fax to 1-985-871-1855
OR E-mail to cccsupport@healthcomp.com

Group Benefits from The Hartford

HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY

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

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Group Retiree Health Insurance – GRIP (The Hartford's Group Retiree Insurance Plan®) Enrollment Form For Initial Enrollment and Subsequent Changes

Policyholder: Northwest Retiree Benefit Trust **Policy Number(s):** AGP-7020, AGP-7022

Please print clearly in ink or type

Retiree's Name: _____
First Middle Last

Street: _____

City, State, Zip: _____ Medicare ID #: _____

Phone Number: _____ E-mail 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 ID #: _____ 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

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:

	Premium Plan Policy AGP-7020	**Value Plan Policy AGP-7022**
Retiree		
Spouse		

Complete this form answering all questions. Please be sure to date and sign the form and return to:

Gilsbar, LLC
PO Box 1590
2100 Covington Centre, Suite B Covington, LA 70434
1-844-413-2843

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.

Billing
You will be billed for all future premium payments directly to your home address. You will have the option to elect to have your premium payments deducted electronically from your checking account. This method of payment is called an Authorization Agreement for Direct Payment. This payment method is explained further in the enclosed Authorization Agreement for Direct Payment literature. If you select this option of payment, please complete the Authorization Agreement Form contained in this package and send it in along with your enrollment form and initial premium

Your employer may have the option available to deduct premium from your pension or retirement fund, contact them for more details.

MEDICARE SUPPLEMENT NOTICES

1. You (includes the retiree and spouse) do not need more than one Medicare supplement policy.
2. If you purchase this coverage, you may want to evaluate your existing health coverage and decide if you need multiple coverages.
3. You may be eligible for benefits under Medicaid and may not need a Medicare supplement policy.
4. If, after obtaining this coverage, you become eligible for Medicaid, the benefits and premiums under your Medicare supplement certificate can be suspended if requested during your entitlement to benefits under Medicaid for twenty-four months. You must request this suspension within ninety days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare supplement certificate (or, if that is no longer available, a substantially equivalent certificate) will be reinstituted if requested within ninety days of losing Medicaid eligibility. If the Medicare supplement certificate provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your certificate was suspended, the reinstituted certificate will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
5. If you are eligible for, and have enrolled in a Medicare supplement certificate by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare supplement certificate can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare supplement certificate under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare supplement certificate (or, if that is no longer available, a substantially equivalent certificate) will be reinstituted if requested within 90 days of losing your employer or union-based group health plan. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D

while certificate was suspended, the reinstituted certificate will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.

6. Counseling services may be available in your state to provide advice concerning your purchase of Medicare supplement insurance and concerning medical assistance through the state Medicaid program, including benefits as a "Qualified Medicare Beneficiary" (QMB) and a "Specified Low-Income Medicare Beneficiary" (SLMB).

PRE-EXISTING CONDITIONS NOTICE

The Hartford Group Retiree Insurance Plan® has a Pre-Existing Conditions Limitation. If a Covered Person consults, or receives medical advice from, a Physician for an Injury or Sickness within the 6 consecutive months prior to the date the Covered Person's insurance starts, then no coverage will be provided for that Injury or Sickness:

- during the first 6 months of the Covered Person's coverage; unless
- the Injury or Sickness starts after the Covered Person has been free of medical care for that condition for 6 consecutive months ending on or after the Covered Person's effective date of coverage.

This limitation applies separately to any increase in coverage.

If a Covered Person is replacing prior coverage, then We may give a credit toward satisfying the limitation for the period continuously insured by the replaced coverage. Details will appear in Your Certificate.

FRAUD NOTICE

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.

DATE AND SIGNATURES

Date: _____ **Retiree Signature:** _____

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