Make Your 2024 Plan Elections

MEDICAL PLAN OPTION RATES – *coverage through The Hartford*

☐ I would like to waive Medical coverage.

Plan Options	Election Options - *check off both Retiree and Spouse coverage if electing both*	
Premium Plus Plan	❑Retiree Coverage Age: 65-69 $163.11 Age: 70-74 $198.45 Age: 75-79 $236.99 Age: 80-84 $277.25 Age: 85-89 $304.46 Age: 90+ $319.48	❑Spouse or Surviving Spouse Coverage Age: 65-69 $163.11 Age: 70-74 $198.45 Age: 75-79 $236.99 Age: 80-84 $277.25 Age: 85-89 $304.46 Age: 90+ $319.48
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 OPTIONS – *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 Coverage ❑Retiree & Spouse Coverage	$43.94 $43.94 $89.26
Dental Plan WITHOUT Medical Coverage	❑Retiree Only ❑Spouse Only or Surviving Spouse Only Coverage ❑Retiree & Spouse Coverage	$46.94 $46.94 $92.26
VISION PLAN OPTIONS – *coverage through Superior Vision. You must be enrolled in the medical plan to elect vision 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 if ADDING a Retiree or Spouse to Medical, Prescription, Dental or Vision coverage.

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:** ___-_____-_____

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

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 other current 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

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 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.

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

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