Airline Retiree Benefit Plan
2018 Benefit Change Form

If you are **not** making any plan changes for 2018, 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 2018 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 OPTIONS – *coverage through Transamerica Premier Life Insurance Company*		
☐ I would like to waive Medical coverage.		
Medical "High" Plan – Select the appropriate age bracket	❑Retiree Age 65 – 69 $147.63 Age 70+ $205.49	❑Spouse Age 65 – 69 $147.63 Age 70+ $205.49
Medical "Low" Plan – Select the appropriate age bracket	❑Retiree Age 65 – 69 $109.39 Age 70+ $146.09	❑Spouse Age 65 – 69 $109.39 Age 70+ $146.09

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	$144.67
	❑ Spouse Only or Surviving Spouse Only Coverage	$144.67
	❑ Retiree & Spouse Coverage	$289.34

DENTAL PLAN OPTIONS – *coverage through MetLife Dental PPO*		
☐ I would like to waive Dental coverage.		
Dental Plan WITH Medical Coverage	❑Retiree Only Coverage ❑Spouse Only or Surviving Spouse Only Coverage $47.74 per month	❑Retiree & Spouse Coverage $91.36 per month
Dental Plan WITHOUT Medical Coverage	❑Retiree Only Coverage ❑Spouse Only or Surviving Spouse Only Coverage $49.08 per month	❑Retiree & Spouse Coverage $94.47 per month

VISION PLAN OPTIONS – *coverage through Superior Vision. You must be enrolled in the medical plan in order to elect vision coverage.*		
☐ I would like to waive Vision coverage.		
Vision Plan	❑ Retiree Only Coverage	$7.62
	❑ Spouse Only or Surviving Spouse Only Coverage	$7.62
	❑ Retiree & Spouse Coverage	$14.68

Note: There is an additional $0.25 VEBA Trust Fee per person in addition to the rates quoted above.

Over for Signature →

Complete the following information if ADDING a spouse or retiree to coverage.

Enrollee's Name: _____
First Middle Last

Enrollee Date of Birth: __/___/_____ **Enrollee SSN: ___-_____-_____**
Enrollee 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)

Please answer the following:
1. Do you have any other health insurance, including an employer or union health plan? ❒ Yes ❒ No

If YES, with which company or union? Please indicate below:

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

2. 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 Plan does not coordinate benefits with any other coverage.

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

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

Name of Coverage	ID # for Coverage	Group # for Coverage

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

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, 2018.

Signature Print Name _____

Retiree Signature and Print Name **Date Signed**

Spouse Signature Print Name _____

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

If you have any questions, please contact the Airline Retiree Benefit Plan Service Center at 1-844-413-1989. Representatives are available Monday through Friday from 7:00 a.m. to 7:00 p.m. (Central time).

If you have made a change in coverage, return the entire form to:
AIRLINE RETIREE BENEFIT PLAN
Administered by Gilsbar, LLC; P. O. Box 998; Covington, LA 70434
Fax to 1-985-871-1855
OR E-mail to adminservices@gilsbar.com