

4. Are you covered by Medicaid? (This is different than Medicare)

Retiree

Yes No

Spouse

Yes No

Release of Information

By joining this plan, I acknowledge that my information will be released to Medicare and other plans as is necessary for treatment, payment and healthcare operations. The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information, I will be dis-enrolled from this plan.

I understand that my signature (or signature of the person authorized to act on behalf of the individual under the laws of the State where the individual resides) on this application means that I have read and understood the contents of this application. If signed by an authorized individual (as described above), this signature certifies that: 1) this person is authorized under State law to complete this enrollment; and 2) documentation of this authority is available upon request by applicable plan vendors or by Medicare.

Fraud Warning

AR, CO, KY, LA, ME, NM, OH, OK, TN and WA Residents: 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 crime and may be subject to fines or confinement in prison.

NJ Residents: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

PA Residents: 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 subjects such person to criminal and civil penalties.

DC and RI Residents: 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.

MD Residents: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefits or knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. FRD100A.MD

X Signature Print Name
Retiree Signature **Print Name**

X
Date Signed

X Spouse Signature Print Name
Spouse/Surviving Spouse Signature (if enrolling)

X
Date Signed

(RM1000GAM)

If you are the authorized representative, please provide the following information:

Name: _____ Address: _____

Phone: _____ Relationship to Retiree: _____

Make Your 2018 Plan Elections

MEDICAL PLAN OPTIONS – coverage through Transamerica Premier Life Insurance Company		
<input type="checkbox"/> I would like to waive Medical coverage.		
Medical Plan WASHINGTON State Residents	<input type="checkbox"/> Retiree All Ages \$135.91	<input type="checkbox"/> Spouse All Ages \$135.91
PRESCRIPTION DRUG COVERAGE – coverage through Express Scripts Medicare™. Enrollees in Prescription Drug Coverage must continue to pay their Medicare Part B premium.		
<input type="checkbox"/> I would like to waive Prescription Drug coverage.		
Choice Plan	<input type="checkbox"/> Retiree Only Coverage	\$144.67
	<input type="checkbox"/> Spouse Only or Surviving Spouse Only Coverage	\$144.67
	<input type="checkbox"/> Retiree & Spouse Coverage	\$289.34
DENTAL PLAN OPTIONS – coverage through MetLife Dental PPO		
<input type="checkbox"/> I would like to waive Dental coverage.		
Dental Plan WITH Medical Coverage	<input type="checkbox"/> Retiree Only Coverage <input type="checkbox"/> Spouse Only or Surviving Spouse Only Coverage \$47.74 per month	<input type="checkbox"/> Retiree & Spouse Coverage \$91.36 per month
Dental Plan WITHOUT Medical Coverage	<input type="checkbox"/> Retiree Only Coverage <input type="checkbox"/> Spouse Only or Surviving Spouse Only Coverage \$50.85 per month	<input type="checkbox"/> 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.		
<input type="checkbox"/> I would like to waive Vision coverage.		
Vision Plan	<input type="checkbox"/> Retiree Only Coverage	\$7.62
	<input type="checkbox"/> Spouse Only or Surviving Spouse Only Coverage	\$7.62
	<input type="checkbox"/> Retiree & Spouse Coverage	\$14.68

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

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 admins@services.gilsbar.com