Airline Retiree Benefit Plan
2019 Benefit Election Form – Washington

Retiree Medical Plan underwritten by
Transamerica Premier Life Insurance Company, a Transamerica company
Prescription Drug Plan provided Express Scripts Medicare™

Please print clearly in ink or type.

Retiree Information

Retiree's Name: _____
First Middle Last

Retiree's Address: _____
Street Address City State Zip Code

Phone Number: _____ **Email Address:** _____

Gender: ❒ Male ❒ Female **Date of Birth:** ____/____/____ **Social Security #:** _____

Date of Retirement: ____/____/____ **Medicare ID #** (on Medicare Card)**:** _____

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

Spouse / Surviving Spouse Information (Complete if enrolling)

Spouse includes your legally married spouse, common law spouse, civil union partner, or domestic partner, if legally recognized in the governing jurisdiction or as otherwise agreed upon between the policyholder and the Insurer.

Spouse's Name: _____
First Middle Last

Gender: ☐ Male ☐ Female **Date of Birth:** ____/___/____ **Social Security #:** _____

Date of Retirement: ____/____/____ **Medicare ID #** (on 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 questions

1. Do you (or your dependent spouse, if enrolling) have any other health insurance, including an employer or union health plan or Medicare Supplement? **Retiree** ☐Yes ☐No **Spouse** ☐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 (or your spouse if enrolling) intend to replace these Medicare Supplement or medical policies with this policy or certificate? **Retiree** ☐Yes ☐No **Spouse** ☐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 that this Group Retiree Plan does not coordinate benefits with any other coverage. You do not need to be enrolled in both plans.

3. Do you (or your spouse, if enrolling) have any other prescription drug coverage, including a State Pharmaceutical Assistance Program? **Retiree** ☐Yes ☐No **Spouse** ☐Yes ☐No

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

Name of Coverage	ID # for Coverage	Group # for Coverage

	Retiree	**Spouse**
4. Are you covered by Medicaid? (This is different than Medicare)	☐Yes ☐No	☐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

Email Address

Retiree Email Address

X Spouse Signature Print Name

Spouse/Surviving Spouse Signature (if enrolling)

X

Date Signed

Email Address

Spouse/Surviving Spouse Email Address (if enrolling)

(RM1000GAM)

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

Name: _____ Address: _____

Phone: _____ Relationship to Retiree: _____

Make Your 2019 Plan Elections

MEDICAL PLAN OPTIONS – *coverage through Transamerica Premier Life Insurance Company*		
☐ I would like to waive Medical coverage.		
Medical Plan WASHINGTON State Residents	❑Retiree All Ages $127.16	❑Spouse All Ages $127.16

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	$150.00
	❑ Spouse Only or Surviving Spouse Only Coverage	$150.00
	❑ Retiree & Spouse Coverage	$300.00

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 $50.85 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 $0.50 VEBA Trust Fee and $1.25 Specialty Care Connect 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 adminservices@gilsbar.com