Airline Retiree Benefit Plan 2019 Benefit Change Form



If you are **not** making any plan changes for 2019, 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 2019 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 ไ	Transamerica Pre	mier Life Insurance	Company (nationwide);	
☐ I would like to waive Medica	l coverage.				
Medical "Premium" Plan – Select the appropriate age bracket	□Retiree Age 65 – 69 Age 70+	\$147.63 \$205.49	□Spouse Age 65 – 69 Age 70+	\$147.63 \$205.49	
Medical "Value" Plan – Select the appropriate age bracket	□Retiree Age 65 – 69 Age 70+	\$109.39 \$146.09	□Spouse Age 65 – 69 Age 70+	\$109.39 \$146.09	
PRESCRIPTION DRUG CO Prescription Drug Coverage must				™. Enrollees in	
☐ I would like to waive Prescrip	tion Drug coverage				
Choice Plan	Coverage or Surviving Spouse C	Only Coverage	\$150.00 \$150.00		
□ Retiree & Spouse Coverage			\$300.00		
DENTAL PLAN OPTIONS -	- coverage through Me	etLife Dental PPC)		
□ I would like to waive Dental of	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 – order to elect vision coverage.	coverage through Sup	erior Vision. You	must be enrolled in	the medical plan in	
☐ I would like to waive Vision of	overage.				
☐ Retiree Onl	\$7.62				
Vision Plan ☐ Spouse Onl ☐ Retiree & S	\$7.62 \$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.

Over for Signature

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

Enrollee's Name	e:				
	First	Middle	Las	t	
Enrollee Date o Enrollee Medica	rollee SSN: our Medicare card)	<u>-</u>			
Are you enrolle	d in Medicare Part	B? ☐ Yes ☐ No	(Must have Medicare	Part B to be eligible for	Medical Plan Option)
Please answer to 1. Do you have a	he following: any other health ins	urance, including	an employer or u	union health plan	.? □ Yes □ No
If YES, with	h which company or	union? Please in	dicate below:		
Person Covered	Company Name	Policy #	Type of Policy	Effective Date	Expiration Date
policies with this	to question 1 is YES policy or certificate for to question 2 is NO	?			
	oup health plan, pleas				
3. Do you have □ Yes □ No	any other prescripti	on drug coverage	including State P	harmaceutical As	sistance Program
If YES, ple	ase list other covera	age and your iden	tification numbe	r(s):	
Name of Cov	rerage I	D # for Coverage		Group # for Coverage	
4. Are you cove	red by Medicaid? (T	his is different that	an Medicare.) □	Yes □ No	
Please sign be	elow. You must s	sign for your re	quested chan	ges to take effe	ect.
I understand tha	t changes or additio	ns I make on this	form will take eff	ect January 1, 20)19.
Signature		Pri	int Name		
Retiree Sign	nature	and	Print Name		Date Signed
Spouse Si	gnature	Pr	int Name		
Spouse/Sur	viving Spouse Sig	nature(if enrollir	ng)		Date Signed
If you have any	lootions places sente	at the Airline Detire	o Bonofit Dlan Ca	nijoo Contor ot 1 9	444 442 4000

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