



Post-65 – GRIP
Benefit Enrollment Form
Plan Year: 1.1.2020 –
12.31.2020



Thank you for your time and attention as you enroll for benefits with the DSRA-BT. Please complete in ink and check the applicable boxes () below.

SECTION 1:

Member Information

Last Name	First Name	M.I.	Date of Birth (mm/dd/yyyy) / /	
Address		City	State	Zip
Telephone Number		Social Security Number	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	
Retirement Date		Email Address		
Salary / Hourly <input type="checkbox"/> Salary <input type="checkbox"/> Hourly		If Hourly, Name of Union		
Medicare # (on Medicare Card)		If Waiting for Medicare #, Check Here: ¹ <input type="checkbox"/>		
Have you enrolled in Medicare Part B? <input type="checkbox"/> Yes <input type="checkbox"/> No				

SECTION 2:

Spouse/Surviving Spouse Information (if Enrolling)

Last Name	First Name	M.I.	Date of Birth (mm/dd/yyyy) / /	
Retirement Date		Social Security Number	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	
Medicare # (on Medicare Card)		If Waiting for Medicare #, Check Here: ¹ <input type="checkbox"/>		
Have you enrolled in Medicare Part B? <input type="checkbox"/> Yes <input type="checkbox"/> No				

¹ Please note, Benistar will reach out to you to obtain your Medicare #.

SECTION 3:

Important Notes to Help You Correctly Select & Compare Your Coverage Election

1. The effective date of your coverage will be the first of the month following your signature date, but not prior to the month in which you turn 65. If you turn 65 on the 1st of the month, your coverage is effective on the 1st of the month prior to your 65th birthday. The exception to this is if you are enrolling through our annual open enrollment period. In this case, the effective date of coverage would be 1/1/2020.
2. Your spouse/domestic partner must have the same medical/prescription coverage as the Retiree.
3. Please review all information and sign and date where necessary.

SECTION 4:

Select Your Coverage



To elect or change your existing Medical coverage, you must complete **The Hartford Enrollment Form** **in addition to this form**. The Hartford form is included in the enrollment packet and can also be found on the DSRA-BT website – go to www.dsrabenefittrust.net and click on “Post-65 Insurance Plans” in the middle of the page.

You may select medical only coverage or medical coverage with prescription drug plans now offered. You cannot select prescription drug coverage only.

Please refer to the 2020 Health Matters Brochure for the monthly medical and prescription drug plan premiums.

Medical Plan Selection

	ELITE AGP-3862	PREMIUM AGP-3845	CHOICE AGP-3846
Retiree	<input type="checkbox"/> M411	<input type="checkbox"/> M011	<input type="checkbox"/> M211
Spouse / Surviving Spouse	<input type="checkbox"/> M415	<input type="checkbox"/> M015	<input type="checkbox"/> M215

Prescription Drug Plan Selection

	PREMIUM	NO COVERAGE
Retiree	<input type="checkbox"/> RX01	<input type="checkbox"/>
Spouse / Surviving Spouse	<input type="checkbox"/> RX05	<input type="checkbox"/>

- Terminate Coverage** If coverage is terminated (Retiree, spouse/domestic partner, and/or dependent) – regardless of the reason – you cannot re-enroll in any of the Post-65 medical/prescription plans at a later date including during a subsequent open enrollment.
- Enroll in an Individual Medicare supplement or Medicare Advantage plan**

DENTAL & VISION

DSRA-BT offers dental and vision coverage through Blue Cross Blue Shield of Michigan (BCBSM). Both plans offer comprehensive coverage. If you would like to enroll in dental and vision coverage or change your current elections please contact Benistar at 1-888-588-6682 or access the BCBSM DSRA-BT enrollment form on the DSRA-BT website – www.dsrabenefittrust.net.

VOLUNTARY LIFE – Delphi hourly retirees are not eligible for this voluntary benefit

If you elected voluntary coverage in the past, your benefit will continue through 2020. **No action is required.** If, however, you are a Delphi salaried retiree and wish to elect voluntary term life insurance with Guardian Life for the first time or make any modifications to your current election, you must complete the Guardian Evidence of Insurability Form. This form can be found on the DSRA-BT website – www.dsrabenefittrust.net.

SECTION 5:
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 health care 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 understand 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.

SECTION 6:
Signature

Retiree Signature:
(If Enrolling) _____

Date: _____

Spouse/Domestic Partner Signature:
(If Enrolling) _____

Date: _____

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

Name: _____

Address: _____

Relationship to Retiree: _____ **Phone:** _____

Please return your completed enrollment form AND your Hartford form if enrolling in or changing medical plans to Mercer, our plan administrator:

Mail: Benistar Admin Services
10 Tower Lane, Suite 100
Avon, CT 06001

Email: memelig@benistar.com

Fax: 1-860-408-7025