DSRA-BT Enrollment Form

DSRA★BENEFIT TRUST
BENEFIT PLANS FOR DELPHI RETIREES

1. Name: _____ _____ _____
   First Name *Middle Name* *Last Name*

   Address _____ _____ _____
   Street *City* *State*

2. Date of Birth: _____ _____ _____ _____
   MM *DD* *YY* Retirement Date:

   _____ _____
   Telephone Number *Email Address*

   ☐ Male ☐ Female
   Gender

   Effective Date: _____ _____ _____
   MM *DD* *YY*

   DOB of Eligible Retiree _____ _____ _____ _____
   MM *DD* *YY* Name of Company Retired From

   _____
   Name of Eligible Retiree

   **If you are enrolling and not the Retiree, include Retiree's Name and Date of Birth*

   ☐ *Male* ☐ *Female* ☐ *S* ☐ *SS* ☐ *DP* ☐ *C* ☐ *D*

   Relationship Codes – S (Spouse); SS (Surviving Spouse); DP (Domestic Partner); C (Child by Birth or Adoption); D (Disabled Child)

   Medicare Id Number if Applicable: _____ Medicare Currently Enrolled: Part A ☐ Part B ☐

   Medicare Effective Date: _____

Please complete your information, sign and return.

Medical carriers offered: Blue Cross Blue Shield, The Hartford and MetLife.

Members: Retiree, Spouse/Domestic Partner, Surviving Spouse or Dependent have the ability to enroll individually in coverage as a Single person if they desire.

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 become Medicare Eligible. If you become Medicare Eligible on the 1st day of the month, your coverage is effective on the 1st of the month prior. 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 1/1/2024.

To elect 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 'Medicare Rates and Plans". You may select medical ONLY coverage, prescription drug ONLY coverage or medical coverage with prescription drug plans now offered.

Your spouse/domestic partner can elect different medical/prescription coverage as the Retiree
To elect 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 'Medicare Rates and Plans".

3. Type of Enrollment

   ☐ New Enrollment BCBS Medicare Advantage

   ☐ New Enrollment Dental / Vision

   ☐ New Enrollment Life Insurance

   ☐ New Enrollment Hartford Supplement Plan

4. Change of Status

   ☐ Address Change

   ☐ Terminate Coverage

   ☐ Add Member

   Other _____

5. Enrollee Information

   ☐ Eligible Retiree

   ☐ Eligible Retiree and Spouse/Domestic Partner

   ☐ Spouse/Domestic Partner/Surviving Spouse

DSRA★BENEFIT TRUST
BENEFIT PLANS FOR DELPHI RETIREES

MEDICARE ELIGIBLE Plan Options

BCBS Medicare Advantage PLAN OPTIONS

☐ New Enrollment DIAMOND Plan	☐ Terminate (DIAMOND Plan)	☐ Retiree
☐ New Enrollment EMERALD Plan	☐ Terminate (EMERALD Plan)	☐ Spouse/Domestic Partner/ Surviving Spouse
☐ New Enrollment RUBY Plan	☐ Terminate (RUBY Plan)	

A Prescription Drug Plan is included with all of the Medicare Advantage Plans

The HARTFORD Medicare Supplement PLAN OPTIONS

☐ There is a separate enrollment form for The Hartford.

BCBSM Standalone PDP

☐ HIGH PDP Plan	☐ Terminate	☐ Retiree
☐ LOW PDP Plan	☐ Terminate	☐ Spouse/Domestic Partner Surviving Spouse

BCBSM Medicare Eligible Dental & Vision ONLY

☐ New Enrollment - High Dental Only	☐ Terminate	☐ Retiree
☐ New Enrollment - Low Dental Only	☐ Terminate	☐ Spouse/Domestic Partner/ Surviving Spouse
☐ New Enrollment - High Detnal/Vision	☐ Terminate	
☐ New Enrollment - Low Dental/Vision	☐ Terminate	

By signing below you are also agreeing to the Terms and Conditions.

7. Signature _____ Date of Signature _____

MM DD YY

DSRA★BENEFIT TRUST
BENEFIT PLANS FOR DELPHI RETIREES

❒ Terms & Conditions

Please Read the following information. The information on this form and the following conditions are part of my contract with Blue Cross® Blue Shield® of Michigan and/or The Hartford.

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.

I am applying for coverage for myself and/or my family member identified on this application under my group's or association's contract with Blue Cross and/or The Hartford. Coverage begins on the date determined by Blue Cross and/or The Hartford. When the carrier(s) accept(s) my application, I and covered members of my family are bound by the terms on the policy and this application. I understand that the submission of false or misleading information or the omission of material information on this form may result in rejection of my enrollment or retroactive termination of my coverage.

Proof of eligibility: I agree to provide proof of my dependent's eligibility for coverage when requested by Blue Cross Blue Shield of Michigan and/or The Hartford.

Authorization: I appoint my group or association to handle all matters of coverage. I am responsible for giving notice to Blue Cross® Blue Shield® of Michigan and/or The Hartford of changes in my status and/or my family's status that affect coverage, such as marriage, divorce, birth, Medicare entitlements, or death of someone covered under the policy. I authorize Blue Cross,The Hartford and/or my Primary Care Physician to obtain the medical records relating to me and my enrolled family members necessary for the coordination of mine/our medical care, administration of my coverage with Blue Cross and/or The Hartford, and for other purposes necessary for Blue Cross and/or The Hartford to fulfill its contractual and statutory obligations.

Release of Information: I acknowledge that Blue Cross and/or The Hartford requires me to provide my Social Security Number. In applying for coverage, I and/or my enrolled family members agree to permit providers and others to release "protected health information" (as that term is used in the Health Insurance Portability and Accountability Act of 1996, as amended) to Blue Cross and/or The Hartford for purpose of administering our coverage.

Instructions for Completion and Submittal of ALL Forms

Complete form by printing a blank form and filling in all necessary information.

Contact Benistar with any question 1-800-236-4782

Completed forms can be faxed or emailed to
Benistar at: memelig@benistar.com
Or if faxing send to: 1-860-408-7025

If mailing send to:
Benistar Service Center
10 Tower Lane, Suite 100
Avon, Ct. 06001

Blue Cross Blue Shield – PDP Standalone
Medicare Eligible / 2024 Rates

STANDALONE PDP MEDICARE Rates

Plan	Rate
High PDP	$109.20
Low PDP	$88.70

Hartford Supplement Plan
Medicare Eligible / 2024 Rates

Admin fee included in rates (plan administration, billing and claims)	INSURED'S AGE BANDED RATES				
	65-69	70-74	75-79	80-84	85+
STANDALONE PLAN RATES					
Elite (Mirrors Plan F)	$ 194.71	$ 239.98	$ 298.50	$ 363.69	$ 407.08
Premium Plus Plan (Mirrors Plan G)	$ 175.23	$ 215.23	$ 267.01	$ 324.64	$ 363.01
Premium Plan	$ 149.15	$ 182.16	$ 224.87	$ 272.42	$ 304.08
Choice Plan	$ 124.16	$ 150.46	$ 184.48	$ 222.38	$ 247.59
Florida Residents ONLY	$ 244.03		*(NO AGEBANDS for FL)*		

Standalone - An administration fee of $7 is included above

MEDICAL PLAN + HIGH RX PLAN - MONTHLY RATES					
Elite (Mirrors Plan F)	$ 296.91	$ 342.18	$ 400.70	$ 465.89	$ 509.28
Premium Plus Plan (Mirrors Plan G)	$ 277.43	$ 317.43	$ 369.21	$ 426.84	$ 465.21
Premium Plan	$ 251.35	$ 284.36	$ 327.07	$ 374.62	$ 406.28
Choice Plan	$ 226.36	$ 252.66	$ 286.68	$ 324.58	$ 349.79
Florida Residents ONLY	$346.23		*(NO AGEBANDS for FL)*		
MEDICAL PLAN + LOW RX PLAN - MONTHLY RATES					
Elite (Mirrors Plan F)	$ 276.41	$ 321.68	$ 380.20	$ 445.39	$ 488.78
Premium Plus Plan (Mirrors Plan G)	$ 256.93	$ 296.93	$ 348.71	$ 406.34	$ 444.71
Premium Plan	$ 230.85	$ 263.86	$ 306.57	$ 354.12	$ 385.78
Choice Plan	$ 205.86	$ 232.16	$ 266.18	$ 304.08	$ 329.29
Florida Residents ONLY	$ 325.73		*(NO AGEBANDS for FL)*		

Medical + RX Plan - An administration fee of $10 is included above

Blue Cross Blue Shield - MAPD
Medicare Eligible / 2024 Rates

Plan	Rate
Diamond	$291.70
Emerald	$237.04
Ruby	$116.90

An administration fee of $10 is included above

Blue Cross Blue Shield - Dental / Vision
(Standalone no Medical) Medicare Eligible / 2024 Rates

LOW PLAN		
	Dental /Vision	Dental Only
Single	$69.79	$62.59
Two Person	$135.33	$120.93

An administration fee of $4.25 is included above

HIGH PLAN		
	Dental /Vision	Dental Only
Single	$73.72	$66.52
Two Person	$143.19	$128.79

An administration fee of $4.25 is included above

Blue Cross Blue Shield
Medical Plan + Dental/ Vision Medicare Eligible / 2024 Rates

LOW PLAN		
	Dental /Vision	Dental Only
Single	$ 65.54	$ 58.34
Two Person	$ 131.08	$ 116.68

HIGH PLAN		
	Dental /Vision	Dental Only
Single	$ 69.47	$ 62.27
Two Person	$ 138.94	$ 124.54

No admin fee when adding Dental to Hartford or BCBSM Medicare Advantage.

MetLife Insurance Plan
Medicare Eligible / 2024 Rates

Retiree Estimated Monthly Cost [i, ii]

	AGE							
Amount	**50-54**	**55-59**	**60-64**	**65-69**	**70-74**	**75-79**	**80-84**	**85-89**
$10,000	$ 2.30	$ 4.30	$ 6.60	$ 12.70	$ 20.60	$ 29.83	$ 48.47	$ 63.38
$20,000	$ 4.60	$ 8.60	$ 13.20	$ 25.40	$ 41.20	$ 59.66	$ 96.94	$ 126.76
$30,000	$ 6.90	$ 12.90	$ 19.80	$ 38.10	$ 61.80	$ 89.49	$ 145.41	$ 190.14
$40,000	$ 9.20	$ 17.20	$ 26.40	$ 50.80	$ 82.40	$ 119.32	$ 193.88	$ 253.52
$50,000	$ 11.50	$ 21.50	$ 33.00	$ 63.50	$ 103.00	$ 149.15	$ 242.35	$ 316.90
$60,000	$ 13.80	$ 25.80	$ 39.60	$ 76.20	$ 123.60	$ 178.98	$ 290.82	$ 380.28
$70,000	$ 16.10	$ 30.10	$ 46.20	$ 88.90	$ 144.20	$ 208.81	$ 339.29	$ 443.66
$80,000	$ 18.40	$ 34.40	$ 52.80	$ 101.60	$ 164.80	$ 238.64	$ 387.76	$ 507.04
$90,000	$ 20.70	$ 38.70	$ 59.40	$ 114.30	$ 185.40	$ 268.47	$ 436.23	$ 570.42
$100,000	$ 23.00	$ 43.00	$ 66.00	$ 127.00	$ 206.00	$ 298.30	$ 484.70	$ 633.80
$110,000	$ 25.30	$ 47.30	$ 72.60	$ 139.70	$ 226.60	$ 328.13	$ 533.17	$ 697.18
$120,000	$ 27.60	$ 51.60	$ 79.20	$ 152.40	$ 247.20	$ 357.96	$ 581.64	$ 760.56

Spouse Monthly Cost [iii]

	AGE							
Amount	**50-54**	**55-59**	**60-64**	**65-69**	**70-74**	**75-79**	**80-84**	**85-89**
$10,000	$ 2.30	$ 4.30	$ 6.60	$ 12.70	$ 20.60	$ 29.83	$ 48.47	$ 63.38
$20,000	$ 4.60	$ 8.60	$ 13.20	$ 25.40	$ 41.20	$ 59.66	$ 96.94	$ 126.76
$30,000	$ 6.90	$ 12.90	$ 19.80	$ 38.10	$ 61.80	$ 89.49	$ 145.41	$ 190.14
$40,000	$ 9.20	$ 17.20	$ 26.40	$ 50.80	$ 82.40	$ 119.32	$ 193.88	$ 253.52
$50,000	$ 11.50	$ 21.50	$ 33.00	$ 63.50	$ 103.00	$ 149.15	$ 242.35	$ 316.90

[v]The rates above do NOT include the $3.50 administration fee. A Fee is only added for the Retiree or Surviving Spouse if they elect to continue coverage.

[vi]Voluntary life plan rates change in five year increments, i.e. 40, 45, 50, etc. The new rate becomes effective 1/1 after the insured enters a new age category.

[vii]Spouse costs are based on the retiree's age.

IMPORTANT – Spouse of retiree has the option of remaining in the plan at the same rate they paid based on retiree's age until age 80 then move to a whole life plan.

DSRA★BENEFIT TRUST
BENEFIT PLANS FOR DELPHI RETIREES

enroll NOW

call 1(888)588-6682

All billing / payment information will be listed on your Benistar invoice.

Benistar

Phone: 1(888)588-6682

Your Call Center and Plan Administrator

Mailing Address:

Benistar Retiree Service Center
10 Tower Lane, Suite100
Avon, CT 06001

Fax Enrollment Forms:
1(860)408-7025