

MEDICARE ELIGIBLE ENROLLMENT

STEP 1 OF 3

DSRA BT Retirees | Complete all applicable fields

A. Member Information

Retiree

FIRST NAME

MIDDLE

LAST NAME

GENDER

SSN

DOB (MM/DD/YYYY)

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Spouse / domestic partner / surviving spouse

FIRST NAME

MIDDLE

LAST NAME

GENDER

SSN

DOB (MM/DD/YYYY)

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B. Contact And Medicare Information

STREET ADDRESS

CITY

STATE

ZIP

PHONE

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EMAIL ADDRESS

Eligible for Medicare: ☐ Yes ☐ No

☐ Currently enrolled in Part A ☐ Part B

MEDICARE ID NUMBER

EFFECTIVE DATE

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☐ Waiting for Medicare number

C. Enrollment Request

☐ Enroll BCBSM Medicare Advantage

☐ Enroll Hartford Supplemental Plan

☐ Enroll Dental / Vision

☐ Enroll Life Insurance

☐ Address change

☐ Add member

☐ Terminate coverage

☐ Other

D. Who Is Enrolling?

☐ Eligible Retiree

☐ Spouse / Domestic Partner / Surviving Spouse

☐ Eligible Retiree And Spouse / Domestic Partner

SELECT COVERAGE

Choose the enrollee type and desired plan action

E. Medicare Eligible Plan Options

Check Enroll or Terminate

BCBSM Medicare Advantage				
	ENROLL	TERMINATE	COVERED PERSON	
Diamond Plan	☐	☐	☐ Retiree	☐ Spouse
Emerald Plan	☐	☐	☐ Retiree	☐ Spouse
Ruby Plan	☐	☐	☐ Retiree	☐ Spouse

The Hartford Medicare Supplemental Plan
Complete this form and the additional Hartford Enrollment Form.

BCBSM Standalone Prescription Drug Plan				
	ENROLL	TERMINATE	COVERED PERSON	
High PDP	☐	☐	☐ Retiree	☐ Spouse
Low PDP	☐	☐	☐ Retiree	☐ Spouse

BCBSM Medicare Eligible Dental and/or Vision Only				
	ENROLL	TERMINATE	COVERED PERSON	
High Dental	☐	☐	☐ Retiree	☐ Spouse
Low Dental	☐	☐	☐ Retiree	☐ Spouse
High Dental with Vision	☐	☐	☐ Retiree	☐ Spouse
Low Dental with Vision	☐	☐	☐ Retiree	☐ Spouse

Coverage Timing And Coordination
Coverage generally begins the first of the month following the signature date, but not before Medicare eligibility.
A Hartford election also requires the Hartford Enrollment Form. A spouse may select different medical or Rx coverage.

F. Signature

By signing below, you agree to the Terms And Conditions on this form.

SIGNATURE

DATE (MM/DD/YYYY)

PRINT NAME

AUTHORIZATION AND SUBMISSION

STEP 3 OF 3

Review, sign and return the completed form

Terms And Conditions

Medicare Disclosure

By joining a plan, I acknowledge that my information may be released to Medicare and other plans as 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 intentionally providing false information may result in disenrollment.

Signature Authority

My signature, or the signature of a person authorized to act on my behalf under applicable state law, means that I have read and understand this application. If signed by an authorized individual, the signature certifies that the person is authorized to complete this enrollment and that documentation of this authority is available upon request.

Application And Eligibility

I am applying for coverage for myself and/or the family member identified on this application under my group or association contract with Blue Cross and/or The Hartford. Coverage begins on the date determined by the carrier. False or misleading information, or omission of material information, may result in rejection or retroactive termination. I agree to provide proof of eligibility when requested.

Authorization And Release

I appoint my group or association to handle coverage matters and will report status changes affecting coverage. I authorize the applicable carriers and providers to obtain records necessary for coordination of care, administration of coverage, and fulfillment of contractual and statutory obligations. I permit release of protected health information as allowed under HIPAA for administration of coverage.

Instructions For Completion And Submission

Complete all applicable fields, select coverage, sign the form, and return it using one of the methods below.

Questions And Electronic Submission

Benistar: 1-800-236-4782

Email: memelig@benistar.com

Fax: 1-860-408-7025

Do not email sensitive information unless secured.

Mail Completed Forms To

Benistar Service Center

10 Tower Lane, Suite 100

Avon, CT 06001

COVERAGE CONTACT INFORMATION

HELP AND CONTACTS

Benistar is your call center and plan administrator

Benistar

1-888-588-6682

Benistar Retiree Service Center
10 Tower Lane, Suite 100
Avon, CT 06001
Fax enrollment forms: 1-860-408-7025

Medical plan information

Blue Cross Blue Shield of Michigan
Benistar Call Center: 1-888-588-6682
BCBSM Claims Department: 1-877-354-2583

Prescription drug information

Blue Cross Blue Shield Prescription Drug Plans
Pre-enrollment inquiries: 1-888-588-6682
Post-enrollment benefits and formulary: 1-877-354-2583

Dental plan information

Blue Cross Blue Shield Nationwide Dental Plans
www.Mibluedentist.com
Dental customer service / Find a Doctor: 1-888-826-8152

Vision plan information

Blue Cross Blue Shield Michigan - Blue Vision VSP
www.VSP.com or www.BCBSM.com
Customer service: 1-800-877-7195

CALL 1-888-588-6682

Billing and payment information is listed on your Benistar invoice.

DSRA MEDICARE PLAN PREMIUMS

FEES INCLUDED IN MEDICAL AND DENTAL/VISION RATES BELOW

BCBSM Standalone Dental Plans

MEDICARE Eligible Plans / 2027 Rates

Plan	Coverage	Rate
High Dental Only	One person	\$ 78.23
	Two person	\$ 152.21
	Family	\$ 226.19
Low Dental Only	One person	\$ 73.56
	Two person	\$ 142.87
	Family	\$ 212.18

Plan	Coverage	Rate
High Dental + Vision	One person	\$ 85.54
	Two person	\$ 166.83
	Family	\$ 248.12
Low Dental + Vision	One person	\$ 80.87
	Two person	\$ 157.49
	Family	\$ 234.11

BCBSM Dental Plan Rates + Medical

MEDICARE Eligible Plans / 2027 Rates

LOW PLAN			HIGH PLAN		
	Dental + Vision	Dental Only		Dental + Vision	Dental Only
Single	\$ 76.62	\$ 69.31	Single	\$ 81.29	\$ 73.98
Two Person	\$ 153.24	\$ 138.62	Two Person	\$ 162.58	\$ 147.96
Family	\$ 229.86	\$ 207.93	Family	\$ 243.87	\$ 221.94

Medicare Standalone Rx Rates

BCBSM – Standalone RX Plans

MEDICARE Eligible / 2027 Monthly Rates

2027 MEDICARE STANDALONE RX PLAN	
High RX Plan	\$ 287.20
Low RX Plan	\$ 254.10

The rates above include the administration fee

Fees Included in medical rates below

Hartford Supplement Plans

MEDICARE Eligible / 2027 Rates

STANDALONE PLAN MONTHLY RATES	INSURED'S AGE BANDED RATES				
	65-69	70-74	75-79	80-84	85+
Choice Plan	\$ 156.11	\$ 188.63	\$ 230.68	\$ 277.52	\$ 308.69
Premium Plan	\$ 187.01	\$ 227.81	\$ 280.60	\$ 339.38	\$ 378.51
Premium Plus Plan (<i>Mirrors G Plan</i>)	\$ 219.24	\$ 268.69	\$ 332.69	\$ 403.92	\$ 451.35
Elite Plan (<i>Mirrors F Plan</i>)	\$ 243.33	\$ 299.27	\$ 371.62	\$ 452.19	\$ 505.83
Florida Residents ONLY	\$ 304.29	FL-All age bands			

MEDICAL + LOW RX PLAN MONTHLY RATES					
Choice Plan + LOW RX	\$ 396.21	\$ 428.73	\$ 470.78	\$ 517.62	\$ 548.79
Premium Plan + LOW RX	\$ 427.11	\$ 467.91	\$ 520.70	\$ 579.48	\$ 618.61
Premium Plus Plan + LOW RX (<i>Mirrors G Plan</i>)	\$ 459.34	\$ 508.79	\$ 572.79	\$ 644.02	\$ 691.45
Elite Plan + LOW RX (<i>Mirrors F Plan</i>)	\$ 483.43	\$ 539.37	\$ 611.72	\$ 692.29	\$ 745.93
Florida Residents ONLY + LOW RX	\$ 544.39	FL-All age bands			

MEDICAL + HIGH RX PLAN MONTHLY RATES					
Choice Plan + HIGH RX	\$ 429.31	\$ 461.83	\$ 503.88	\$ 550.72	\$ 581.89
Premium Plan + HIGH RX	\$ 460.21	\$ 501.01	\$ 553.80	\$ 612.58	\$ 651.71
Premium Plus Plan + HIGH RX (<i>Mirrors G Plan</i>)	\$ 492.44	\$ 541.89	\$ 605.89	\$ 677.12	\$ 724.55
Elite Plan + HIGH RX (<i>Mirrors F Plan</i>)	\$ 516.53	\$ 572.47	\$ 644.82	\$ 725.39	\$ 779.03
Florida Residents ONLY + HIGH RX	\$ 577.49	FL-All age bands			

The plans above include Silver & Fit Program

MetLife Insurance Plans

MEDICARE Eligible / 2027 Rates



The rates below **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.

Amount	50-54	55-59	60-64	65-69	70-74	75-79	80-84	85-89	90-94	95+
\$10k	\$ 2.51	\$ 4.44	\$ 6.99	\$ 13.31	\$ 21.95	\$ 36.40	\$59.14	\$ 97.58	\$ 158.09	\$ 256.11
\$20k	\$5.02	\$ 8.88	\$ 13.98	\$ 26.62	\$ 43.90	\$ 72.80	\$ 118.28	\$ 195.16	\$ 316.18	\$ 512.22
\$30k	\$ 7.53	\$ 13.32	\$ 20.97	\$ 39.93	\$ 65.85	\$ 109.20	\$ 177.42	\$ 292.74	\$ 474.27	\$ 768.33
\$40k	\$ 10.04	\$ 17.76	\$ 27.96	\$ 53.24	\$ 87.80	\$ 145.60	\$ 236.56	\$ 390.32	\$ 632.36	\$ 1,024.44
\$50k	\$ 12.55	\$ 22.20	\$ 34.95	\$ 66.55	\$ 109.75	\$ 182.00	\$ 295.70	\$ 487.90	\$ 790.45	\$ 1,280.55
\$60k	\$ 15.06	\$ 26.64	\$ 41.94	\$ 79.86	\$ 131.70	\$ 218.40	\$ 354.84	\$ 585.40	\$ 948.54	\$ 1,536.66
\$70k	\$ 17.57	\$ 31.08	\$ 48.93	\$ 93.17	\$ 153.65	\$ 254.80	\$ 413.98	\$ 683.06	\$ 1,106.63	\$ 1,792.77
\$80k	\$ 20.08	\$ 35.52	\$ 55.92	\$ 106.48	\$ 175.60	\$ 291.20	\$ 473.12	\$ 780.64	\$ 1,264.72	\$ 2,048.88
\$90k	\$ 22.59	\$ 39.96	\$ 62.91	\$ 119.79	\$ 197.55	\$ 327.60	\$ 532.26	\$ 878.22	\$ 1,422.81	\$ 2,304.99
\$100k	\$ 25.10	\$ 44.40	\$ 69.90	\$ 133.10	\$ 219.50	\$ 364.00	\$ 591.40	\$ 975.80	\$ 1,580.90	\$ 2,561.10
\$110k	\$ 27.61	\$ 48.84	\$ 76.89	\$ 146.41	\$ 241.45	\$ 400.40	\$ 650.54	\$ 1,073.38	\$ 1,738.99	\$ 2,817.21
\$120k	\$ 30.12	\$ 53.28	\$ 83.88	\$ 159.72	\$ 263.40	\$ 436.80	\$ 709.68	\$ 1,170.96	\$ 1,897.08	\$ 3,073.32

Spousal coverage only available up to \$50,000.

-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.

-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.