THE HARTFORD

Senior Medical Insurance Plan Enrollment Form

Hartford Life and Accident Insurance Company **Policy Numbers:** AGP- 3192, AGP-3230

Policyholder: Delphi Salaried Retiree Association Benefit Trust

Please print clearly in ink or type

Retiree's Name: _____
First Middle Last

Street: _____

City, State, Zip: _____ Social Security # : _____

Phone Number: _____

Gender: ☐ Male ☐ Female Date of Birth _____

Date of Retirement : _____ Medicare/HIC # : _____

Spouse's Name (Only if enrolling): _____
First Middle Last

Gender: ☐ Male ☐ Female Date of Birth _____: Social Security #: _____

Date of Retirement _____ Medicare/HIC# _____

To the best of your knowledge:

1. Do you (or your spouse, if enrolling) have another policy which supplements Medicare or certificate in force including a health care service contract or health maintenance organization (HMO) contract?

Retiree ☐ Yes ☐ No **Spouse** ☐ Yes ☐ No If yes, please indicate below:

Covered Person	Company Name	Policy Number	Effective Date	Expiration Date

2. Do you (or your spouse, if enrolling)have any other health insurance including an employer health plan? **Retiree** ☐ Yes ☐ No **Spouse** ☐ Yes ☐ No If yes, please indicate below:

Covered Person	Company Name	Policy Number	Type of Policy	Effective Date	Expiration Date

3. If the answer to question 1 or 2 is yes, do you (or your spouse, if enrolling) intend to replace these medical or health policies with this policy? **Retiree** ☐ Yes ☐ No **Spouse** ☐ Yes ☐ No
If yes, for what reason are you (or your spouse, if enrolling) replacing the coverage?

☐ Additional Benefits
☐ Fewer benefits and lower premiums
☐ No change in benefits, but lower premiums
☐ Other (please specify)

4. Are you covered by Medicaid? **Retiree** ☐ Yes ☐ No **Spouse** ☐ Yes ☐ No

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Check Desired Coverage:

	AGP-3192	AGP-3230
Retiree	☐	☐
Spouse	☐	☐

Your Premium Payment* must accompany this enrollment form. See the attached Plan Chart to find the appropriate premium for the Plan you have selected. Please be sure to date and sign this form answering all questions. Make your check payable to Mercer Health & Benefits Administration LLC, and mail it in the enclosed envelope to:

Benistar Administrative Services, Inc. (BASI)
10 Tower Lane, First Floor
Avon, CT 06001
1-888-588-6682

You will be billed for all future premium payments directly to your home address. You will have the option to elect to have your premium payments deducted electronically from your checking account. This method of payment is called an Authorization Agreement for Direct Payment. This payment method is explained further in the enclosed Authorization Agreement for Direct Payment literature. If you select this option of payment, please complete the Authorization Agreement Form contained in this package and send it in along with your enrollment form and initial premium.

*Your employer may have the option available to deduct premium from your pension or retirement fund, contact them for more details.

I (we) understand and agree that any pre-existing conditions (conditions for which medical advice or treatment has been received or recommended in the past six months) will not be covered until six consecutive months after the effective date of coverage. I (we) understand that if I (we) plan on replacing any existing group medical coverage with this plan, then this pre-existing condition limitation will be waived to the extent it was satisfied under the previous policy. I (we) understand that coverage will become effective on the first day of the month following receipt by the Company of this enrollment form and first premium payment.

Date: _____ Retiree Signature: _____

Date: _____ Spouse Signature: _____
(if enrolling)