

## Group Retiree Health Insurance Plan Enrollment Form



**Hartford Life & Accident Insurance Company**

**Policy Numbers:** AGP-3845, 3846,3862

Policyholder: Delphi Salaried Retiree Association Benefit

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Please print clearly in ink or type

Retiree's Name: \_\_\_\_\_  
   First  Middle  Last

Street: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_ Medicare/HIC # \_\_\_\_\_

Phone Number: \_\_\_\_\_ Email Address: \_\_\_\_\_

Gender     Male     Female    Date of Birth \_\_\_\_\_    Social Security # \_\_\_\_\_

Date of Retirement \_\_\_\_\_ Have you enrolled in Medicare Part B?     Yes     No

If no, when do you intend to enroll? \_\_\_\_\_

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Dependent Spouse's Name (Only if enrolling): \_\_\_\_\_  
   First  Middle  Last

Gender     Male     Female    Date of Birth \_\_\_\_\_    Social Security # \_\_\_\_\_

Medicare/HIC # \_\_\_\_\_    Date of Retirement \_\_\_\_\_

Has your dependent spouse enrolled in Medicare Part B?     Yes     No

If no, when does he/she intend to enroll? \_\_\_\_\_

To the best of your knowledge:

1. Do you or your dependent spouse, dependent parent or dependent child, if enrolling, have any other health insurance including an employer health plan?    **Retiree**     Yes     No    **Dependent Spouse**     Yes     No

If so, with which company? What kind of policy? \_\_\_\_\_

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

2. If the answer to question 1 is yes, do you or your spouse, child, or parent, if enrolling intend to replace these medical or health policies with this policy or certificate?    **Retiree**     Yes     No  
**Dependent Spouse**     Yes     No

If yes, for what reason are you (or your dependent spouse, child or parent, if enrolling) replacing the coverage?

- |  |  |
|--|--|
| <input type="checkbox"/> Additional Benefits               | <input type="checkbox"/> No change in benefits, but lower premiums |
| <input type="checkbox"/> Fewer benefits and lower premiums | <input type="checkbox"/> Other (please specify)                    |
| <input type="checkbox"/> Integration with Medicare         |  |

3. Are you covered by Medicaid?

**Retiree**     Yes     No    **Dependent Spouse**     Yes     No

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Check Desired Coverage:

	AGP-3845	AGP-3846	AGP-3862
Retiree			
Dependent Spouse			

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Complete this form answering all questions. Please be sure to date and sign the form and return to:

Benistar Administrative Services, Inc. (BASI)  
10 Tower Lane, First Floor  
Avon, CT 06001  
1-800-236-4782

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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: \_\_\_\_\_ Dependent Spouse Signature: \_\_\_\_\_  
(if enrolling)