DSRA★BENEFIT TRUST
BENEFIT PLANS FOR DELPHI RETIREES

Benefit Enrollment and Change of Status Form

DSRA Benefit Trust

This is an electronic fillable form. Please complete by typing in your information and signing electronically or print, complete and sign.

Carrier: Blue Cross Blue Shield of Michigan (BCBSM) – Medical, Prescription Drug, Dental and Blue Vision. PBGC Recipient, Spouse/Domestic Partner, Two Person, Dependent or Qualified Family Member(QFM) have the ability to enroll individually in any plan level of coverage as a Single person if they desire.

*Select the Coverage for the individual(s) enrolling in the plan below under one (1) Enrollment form if you are a PBGC recipient and/or Spouse and/or Dependent enrolling in the plan as a Family. If two (2) people are enrolling in the plan, selecting enrollment as a single on two (2) forms offers better pricing. The two family members are not required to have the same coverage if they enroll individually. Each family member must complete their own form and send payment individually for their plan options.

☑ SECTION 1: Type of Request

☐ HCTC Enrolled Spouse*	☐ New Enrollment – Non AMP*	☐ HCTC AMP* Enrollment or Change	☐ Change of Status
*If you were previously enrolled as a "couple," you can enroll as two individuals to reduce your overall monthly premium beginning in 2020. You must provide proof of eligibility when enrolling.	*If you have not initiated your PBGC pension payments or if you elect to receive the HCTC subsidy yearly via IRS form 8885 check here.	*Advanced Monthly Payment (AMP) enrollment must include proof of eligibility with this form.	☐ Address Change ☐ Add Dependents ☐ Terminate Contract ☐ Other ____________

☑ SECTION 2: Enrollee Information

Are you electing the same health plan that you are currently utilizing? ☐ Yes ☐ No

Who is enrolling? ☐ PBGC recipient only ☐ PBGC recipient and Spouse/Domestic partner ☐ PBGC recipient and Family ☐ Spouse/Domestic Partner ☐ Dependent

Last Name	First Name	M.I.	Date of Birth (mm/dd/yyyy) / /
Address	City	State	Zip
Telephone Number	Social Security Number	Gender ☐ Male ☐ Female	
Medicare ID Number if Applicable:	Medicare Effective Date	Medicare Currently Enrolled: Part A Part B	Email Address
Spouse/Dependent Medicare ID Number if Applicable:	Spouse/Dependent Medicare Effective Date		
Retirement Date from Delphi*	Salary / Hourly ☐ Salary ☐ Hourly	If Hourly, Name of Union	
Effective Date	Form of Payment *Must be received by the 10th day of the month of the Effective Date ☐Check (only form of payment accepted by IRS/HCTC AMP) EFT (Non-AMP option only)		
DSRA Trust QFM Eligible	Retiree Name*	Retiree Date of Birth* / /	

*If you are enrolling and not the Retiree, include Retiree's Name and Date of Birth and Retirement Date from Delphi in the provided fields above.

☑ SECTION 3: Participating Dependent(s)

Name (First, MI, Last)	DOB (mm/dd/yyyy)	SSN	Gender	Relationship Code [1]
			☐ M ☐ F	☐ S ☐ SS ☐ DP ☐ C ☐ D
			☐ M ☐ F	☐ S ☐ SS ☐ DP ☐ C ☐ D
			☐ M ☐ F	☐ S ☐ SS ☐ DP ☐ C ☐ D
			☐ M ☐ F	☐ S ☐ SS ☐ DP ☐ C ☐ D

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

☑ SECTION 4: Medical Coverage Selection

Select your coverage by choosing one box in this section. For HCTC-eligible AMP qualifying members, only Medical/Dental/Vision benefits must be selected.

MEDICAL COVERAGE

Pre-65 & Pre-65 Medicare Disabled ONLY. For Post-65 Medical, please contact Benistar 1-888-588-6682

GOLD

Medical / Dental / Vision	Terminate Coverage
☐	☐

SILVER – Only medical plan available to pre-65 Medicare Disabled

Medical / Dental / Vision	Medical / Dental	Medical / Vision	Medical Only	Terminate Coverage
☐	☐	☐	☐	☐

BRONZE

Medical / Dental / Vision	Medical / Dental	Medical / Vision	Medical Only	Terminate Coverage
☐	☐	☐	☐	☐

COPPER

Medical / Dental / Vision	Medical / Dental	Medical / Vision	Medical Only	Terminate Coverage
☐	☐	☐	☐	☐

STAND-ALONE COVERAGE

Dental / Vision	Dental Only	Vision Only	Terminate Coverage
☐	☐	☐	☐

☑ SECTION 5: Signature

Retiree Signature: (If Enrolling) ____________________ **Date:** __________

Spouse/Domestic Partner Signature: (If Enrolling) ____________________ **Date:** __________

This enrollment form in conjunction with form 13441-A must be completed in their entirety and proof of eligibility (i.e.- 1099-R) included in order to be enrolled in the HCTC program. Any missing information will delay your enrollment in being processed. All enrollment forms, including the 13441-A form if needed, will be faxed, emailed or mailed to Benistar. Use the contact information in "Instructions for Completion and Submittal of ALL Forms" on Page 3 of this form.

[End of Enrollment Form to be Submitted. Return pages 1 - 2 only.]

Instructions for Completion and Submittal of ALL Forms

Complete form by either (a) printing a blank form and filling in all necessary information in ink or (b) open the form and complete electronically (you are able to sign your form electronically or by printing). Don't forget to save your form on your computer once you have completed.

Contact Benistar with any question 888-588-6682.

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 DSRA-BT Service Center
10 Tower Lane, Suite 100
Avon, Ct. 06001

☑ SECTION 6: Eligibility Requirements for DSRA-BT Subsidy

Under Age 55 and Special Circumstances

1. You must select a medical plan in order to be eligible to receive the DSRA-BT subsidy (as outlined below).
2. If you are electing the SILVER, BRONZE, or COPPER medical plans, you must check the correct box if you want dental and vision coverage since these plans are not automatically bundled. If you are electing the GOLD medical plan, you will automatically be enrolled in vision and dental coverage.
3. "Family Coverage" is coverage including three (3) or more individuals.
4. All Pre-65 Medicare Disabled will be placed in the eligible Medicare plan. If they have a pre-65 non-Medicare spouse and they have been on Medicare for more than 24 months, the spouse qualifies for a DSRA-BT Special Circumstance subsidy. The spouse must fill out a separate enrollment form.
5. To be eligible for the DSRA-BT provided Special Circumstance Subsidy, you must be a Delphi Salaried retiree who retired on or before April 1, 2009. Enrollees age 55 through 64 that are receiving monthly pension benefit from PBGC are not eligible for monthly subsidy distributions. If you are under 55 or 55 to 64 and received your pension in a lump sum and thus are not receiving a PBGC pension you qualify for a Special Circumstance Subsidy.
6. **If the HCTC is not extended** then those who retired on or before April 1, 2009 and have medical coverage through the DSRA-BT qualify for a Special Circumstance subsidy. Only one subsidy per family unless there are two qualifying Delphi retirees in the household.
7. The effective date of coverage requested will be the first of the month following your signature date, unless a future effective date is listed. The exception to this is if you are enrolling through our annual open enrollment period. In this case, the effective date of your coverage will be 1/1/2020.

Eligibility Requirements for DSRA-BT Subsidy for Qualified Family Member (QFM)

1. You must select a medical plan in order to be eligible to receive the DSRA-BT subsidy (as outlined below).
2. All QFM's must complete the entire "Enrollee Information" section (section 2) and check the QFM checkbox to be considered for the subsidy.
3. DSRA-BT will review and potentially modify subsidy amount each calendar year.
4. Subsidy is dependent on retiree's date of retirement, age, and QFM's age.
   - 4.1. Retiree must be a Delphi Salaried retiree and retired on or before to April 1, 2009.
   - 4.2. QFM must be under 65.
   - 4.3. Retiree must be 67 - 68 years of age. The subsidy ceases when the retiree reaches the age of 69.
   - 4.4 If HCTC is not extended, QFM is only eligible for a subsidy for 24 months once the retiree reaches age 65 and is under age 69.
5. QFM subsidy automatically ends when they turn 65 due to Medicare eligibility.

	2020 Monthly DSRA-BT Subsidy Amount (HCTC Extended)		
	Single	Two Person	Family
Under Age 55 & Special Circumstance*	$640	$1,280	$1,900
Under Age 65 & Medicare Disabled	$880	$1760	N/A
Under 65 QFM	$445	N/A	N/A
Post-65	***No subsidy available for post-65 members***		N/A

	2020 Monthly DSRA-BT Subsidy Amount (HCTC Not Extended)		
	Single	Two Person	Family
Under Age 55 & Special Circumstance*	$240	$480	$710
Under Age 65 & Medicare Disabled	$660	$1320	N/A
Under 65 QFM	$240	N/A	N/A
Post-65	***No subsidy available for post-65 members***		N/A

☑ SECTION 7: Plans and Rates – Non HCTC

NON-HCTC AMP ELIGIBLE RETIREES UNDER AGE 65

GOLD	Medical / Dental / Vision *			
Single	$1,449.53			
Two-Person	$3,422.03			
Family	$4,343.60			
SILVER	**Medical / Dental / Vision**	**Medical / Dental**	**Medical / Vision**	**Medical Only**
Single	$1,227.77	$1,222.13	$1,161.32	$1,155.68
Two-Person	$2,889.79	$2,878.51	$2,756.89	$2,745.61
Family	$3,678.31	$3,659.59	$3,445.74	$3,427.02
BRONZE	**Medical / Dental / Vision**	**Medical / Dental**	**Medical / Vision**	**Medical Only**
Single	$958.60	$952.96	$892.15	$886.51
Two-Person	$2,243.78	$2,232.50	$2,110.88	$2,099.60
Family	$2,870.80	$2,852.08	$2,638.23	$2,619.51
COPPER	**Medical / Dental / Vision**	**Medical / Dental**	**Medical / Vision**	**Medical Only**
Single	$838.08	$832.44	$771.63	$765.99
Two-Person	$1,954.53	$1,943.25	$1,821.63	$1,810.35
Family	$2,509.23	$2,490.51	$2,276.66	$2,257.94

* All **GOLD** Plans include Medical, Dental and Vision Coverage

MEDICARE DISABLED RETIREES OR ELIGIBLE DEPENDENTS UNDER AGE 65

SILVER	Medical / Dental / Vision	Medical / Dental	Medical / Vision	Medical Only
Single	$1,826.35	$1,821.79	$1,764.24	$1,759.68
Two-Person	$3,632.70	$3,623.58	$3,508.48	$3,499.36

STAND-ALONE (NO MEDICAL) – UNDER 65

	Dental / Vision	Dental Only	Vision Only
Single	$76.09	$70.45	$5.64
Two-Person	$148.18	$136.90	$11.28
Family	$255.29	$236.57	$18.72

STAND-ALONE (NO MEDICAL) – PRE-65 MEDICARE DISABLED and RETIREES POST-65

	Dental / Vision	Dental Only	Vision Only
Single	$70.67	$66.11	$4.56
Two-Person	$137.34	$128.22	$9.12
Family	$204.01	$190.33	$13.68

Note: The pre-65 spouse of a Medicare eligible retiree must fill out a separate enrollment form if the retiree is signing up for Dental &/or Vision. Post-65 dental enrollees must include their Medicare number in section 2 to receive the post-65 price.

☑SECTION 8: Eligibility Requirements for HCTC Advanced Monthly Payment (AMP) Program

1. The Advance Monthly payment (AMP) program allows you to pay 27.5% of the premium to the IRS directly. The IRS then pays the entire premium for your insurance.
2. Retiree Eligibility: To be eligible for the HCTC, you must meet one of the following:
   a. An eligible trade adjustment assistance recipient, alternative TAA recipient or reemployment TAA recipient,
   b. An eligible Pension Benefit Guaranty Corporation payee, or
   c. The family member of an eligible TAA, ATAA, or RTAA recipient or PBGC payee who is deceased or who finalized a divorce with you.
3. You are not eligible for the HCTC if you:
   a. Can be claimed as a dependent on another person's federal income tax return or
   b. Are enrolled in Medicare, Medicaid, the Children's Health Insurance Program, or the Federal Employees Health Benefits Program or are eligible to receive benefits under the U.S. military health system (TRICARE)
4. Qualified Family Member (QFM) Eligibility: To be eligible for the HCTC, you must be a family member of a Retiree who is eleigible for 24 months from the event date of one of the following:
   a. Retiree begins Medicare (Medicare care required)
   b. Retiree Death (death certificate required). Note: If the Surviving Spouse option was chosen, the spouse is eligible for the HCTC until they turn 65.
   c. Divorce (divorce decree required). Note: If the spouse is receiving a portion of the PBGC pension they are eligible for the HCTC until they turn 65,
5. For more information on DSRA-BT, HCTC, or AMP registration including sample completed forms, visit www.dsrabenefittrust.net or www.irs.gov/hctc or call Benistar at 1-888-588-6682.

☑ SECTION 9: HCTC Plans and Rates

HCTC AMP ELIGIBLE RETIREES UNDER AGE 65

GOLD	Medical / Dental / Vision	27.5% Member Cost
Single	$1,449.53	$398.62
Two-Person	$3,422.03	$941.06
Family	$4,343.60	$1,194.49
SILVER	**Medical / Dental / Vision**	**27.5% Member Cost**
Single	$1,227.77	$337.64
Two-Person	$2,889.79	$794.69
Family	$3,678.31	$1,011.54
BRONZE	**Medical / Dental / Vision**	**27.5% Member Cost**
Single	$958.60	$263.62
Two-Person	$2,243.78	$617.04
Family	$2,870.80	$789.47
COPPER	**Medical / Dental / Vision**	**27.5% Member Cost**
Single	$838.08	$230.47
Two-Person	$1,954.53	$537.50
Family	$2,509.23	$690.04

☑ SECTION 10: Health Savings Account (only for Bronze of Copper medical options)

Health Savings Account – Only for those who elect the BRONZE or COPPER medical options

PLEASE READ:

1. If you are enrolling in the BRONZE or COPPER High Deductible Health Plans, you are eligible for a Health Savings Account at the bank of your choice!
2. You may contribute toward your Health Savings Account up to the 2020 IRS annual dollar maximum depending on your level of coverage. If you have single coverage, you can contribute up to the single HSA maximum, or $3,550. If you have family coverage (i.e. if you elect Two-Person or Family), you can contribute up to the family maximum, or $7,100.
3. You are not eligible to contribute to a Health Savings Account if you are covered under a traditional health insurance plan, Medicare, or a military health insurance plan.
4. Individuals age 55 and older who are not enrolled in Medicare are eligible to contribute an additional amount above the regular limits. The additional "catch-up contribution" for 2020 is $1,000. A catch-up contribution can be made each year until enrolled in Medicare.

☑ SECTION 11:

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.

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. Coverage begins on the date determined by Blue Cross. When Blue Cross accepts 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.
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 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 and/or my Primary Care Physician to obtain the medical records relating to me and my enrolled family members necessary for the coordination of our medical care, administration of my coverage with Blue Cross, and for other purposes necessary for Blue Cross to fulfill its contractual and statutory obligations.

Release of Information: I acknowledge that Blue Cross requires me to provide my Social Security Number. In applying for coverage, I and 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 for purpose of administering our coverage. Upon my request, Blue Cross will tell me where the information was sent.