RETIREE BENEFIT PLAN
DALRC
FOR DELTA RETIREES

THE HARTFORD

Group Retiree Insurance Plan Enrollment Form
Hartford Life & Accident Insurance Company
Policyholder: **DALRC Retiree Benefit Trust** Policy Numbers: **AGP-1780**

Please print clearly in ink or type

Delta Retiree's Name: _____
First Middle Last

Medicare # (on Medicare Card): _____ ☐ check if waiting for Medicare #

Phone Number: _____ Address: _____

City _____ State_____ Zip code _____ Email address _____

Gender: ☐ M ☐ F Date of Birth: _____ Social Security #: _____

Retirement Date: _____ Have you enrolled in Medicare Part B? ☐ **Yes** ☐ **No**

Spouse/Surviving Spouse Name (if enrolling): _____
First Middle Last

Gender: ☐ M ☐ F Date of Birth _____ Social Security # _____

Medicare # (on Medicare Card): _____Retirement Date: _____

Has the spouse/surviving spouse enrolled in Medicare Part B? ☐ **Yes** ☐ **No**

To the best of your knowledge:

1. Do you [or your dependent spouse if enrolling] have any other health insurance including an employer health plan? **Retiree** ☐ **Yes** ☐ **No**

Spouse/Surviving Spouse ☐ **Yes** ☐ **No**

If YES, with which company? Please indicate below:

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

2. If the answer to question 1 is YES, do you [or your spouse if enrolling] intend to replace these medical or health policies with this policy or certificate? **Retiree** ☐ **Yes** ☐ **No**

Spouse/Surviving Spouse ☐ **Yes** ☐ **No**

Note: If the answer to question 2 is NO and you intend to continue coverage in another employer group health plan, please be aware this Group Retiree Plan does not coordinate benefits with any other coverage.

3. Do you [or your dependent spouse if enrolling] have any other prescription drug coverage including a State Pharmaceutical Assistance Program? **Retiree** ☐ **Yes** ☐ **No**

Spouse/Surviving Spouse ☐ **Yes** ☐ **No**

If YES, please list other coverage and your identification number(s):

Name of Coverage	ID# for Coverage	Group # for Coverage

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

Release of Information:

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 disenrolled 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.

Retiree Signature: _____ **Date**: _____

Spouse/Surviving Spouse Signature: _____ **Date:** _____
(Required if enrolling)

If you are the authorized representative, please provide the following information:

Name: _____

Address: _____

Phone: _____ Relationship to Retiree: _____

2010 DALRC Retiree Benefit Plan Elections

Please indicate below the coverage(s) in which you wish to enroll. 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 turn 65. If you turn 65 on the 1st of the month, your coverage is effective on the 1st of the month prior to your 65th birthday.

MEDICAL/PRESCRIPTION DRUG CHANGE INFORMATION – Check the appropriate box(es). *Retiree and spouse must have the same level of coverage.* ***Monthly premium rate reflects your cost after the Delta subsidy is applied.***

Please change my medical/prescription plan to:	**2010 Monthly Premium***	
Medical with Emerald Rx Plan	**Smoker**	**Non-Smoker**
Retiree	☐ $281.90 (MS91, RM01, ES91)	☐ $271.19 (MS91, RM01, ES91)
Retiree & Spouse	☐ $563.80 (MS91, MS95, RM02, ES92)	☐ $542.38 (MS91, MS95, RM02, ES92)
Spouse/Surviving Spouse	☐ $281.90 (MS95, RM05, ES95)	☐ $271.19 (MS95, RM05, ES95)
Medical with Opal Rx Plan	**Smoker**	**Non-Smoker**
Retiree	☐ $194.87 (MS91, RM11, ES91)	☐ $184.16 (MS91, RM11, ES91)
Retiree & Spouse	☐ $389.74 (MS91, MS95, RM12, ES92)	☐ $368.32 (MS91, MS95, RM12, ES92)
Spouse/Surviving Spouse	☐ $194.87 (MS95, RM15, E9P5)	☐ $184.16 (MS95, RM15, ES95)

Provided at no additional premium with your Medical/Prescription Plan:

- Health Advocate
- Identity Protection Support Service
- Travel Assistance Program
- EstateGuidance On-Line Will Preparation
- Hearing Service Discount Plan

**Monthly premium rate reflects your cost after the Delta subsidy is applied*

*** When enrolling in the Medical/Rx plan your Medicare # is required.*

Vision Plan Information – Check the appropriate box.		
Vision Plan	☐ **Retiree** **(V001)**	$6.06
	☐ **Retiree & Spouse** **(V002)**	$11.45
	☐ **Spouse only/Surviving Spouse** **(V005)**	$6.06
Dental Plan Information – Check the appropriate box.		
PPO	☐ **Retiree** **(D421)**	$47.97
	☐ **Retiree & Spouse** **(D422)**	$96.98
	☐ **Spouse only/Surviving Spouse** **(D425)**	$47.97
DHMO*	☐ **Retiree** **(D001)**	$21.33
	☐ **Retiree & Spouse** **(D002)**	$42.46
	☐ **Spouse only/Surviving Spouse** **(D005)**	$21.33

** The Dental HMO is not available in the following states: AK, HI, ME, MT, NV, NH, NM, ND, PR, RI, SD, VI, VT, WV and WY.*

Please return entire form to:
DALRC Benefit Plan
P.O. Box 14464, Des Moines, IA 50306-9468
OR
Fax to 1-515-365-1520
OR
Via the website at www.DALRCbenefitplans.com

Important Information about Medicare Part D – Low Income Subsidy:

You may be able to get extra help to pay for the monthly premiums, annual deductibles, and co-payments related to your Medicare prescription drug costs. Medicare provides this program for people who have limited income and resources. If you qualify, this assistance will count toward your out-of-pocket costs. You may qualify if your yearly income in 2008 was less than $15,600 (single with no dependents) or $21,000 (married and living with your spouse with no dependents), and your resources are less than $11,990 (single) or $23,970 (married and living with your spouse). Resources include savings and stocks but not a home or car. **If you aren't getting extra help, here's how to find out if you qualify:**

- Call the Social Security Administration at **1-800-772-1213,** 7 a.m. to 7 p.m., Monday through Friday. TTY/TDD users should call **1-800-325-0778**, or
- Visit www.socialsecurity.gov (click on Medicare" then "Learn about getting help with prescription drug costs"), or
- Apply at your State Medical Assistance (Medicaid) office