RETIREE MEDICAL INSURANCE PLAN ELECTION FORM

Medical plan is underwritten by: Transamerica Premier Life Insurance Company

You must return your election form to put your coverage in force!

Retiree Information (Please print)

Name		Date of Birth	
Address		Social Security Number	
City		Gender	Phone Number
State	Zip Code	Medicare ID# *(from Medicare ID card):*	
Hospital (Part A) effective date *(from Medicare ID card):*		Medical (Part B) effective date *(from Medicare ID card):*	
Email Address		Date of Retirement	

Spouse Information (if enrolling)

Name	Date of Birth
Gender	Social Security Number
Date of Retirement	Medicare ID# *(from Medicare ID card):*
Hospital (Part A) effective date *(from Medicare ID card):*	Medical (Part B) effective date *(from Medicare ID card):*

Please Choose Type of Coverage

Effective Date: ***Check Desired Coverage*:**	Retiree Only	Retiree & Spouse	Surviving Spouse
Medical Plan			

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Please Complete the Following Information:
Do you (or your spouse, if enrolling) currently have any Medicare Supplement policies or certificates in force (including Health Maintenance Organization contract or Health care service contract)?

Retiree (if enrolling): ☐ Yes ☐ No Spouse (if enrolling): ☐Yes ☐No

a) If YES*, with which company? ____

b) What kind of policy / certificate? ____

c) Length of time you have had coverage? ______________________ Years_________ Months_________

d) Will you be replacing the above listed policy/certificate upon acceptance of this enrollment form?
☐ Yes ☐ No

*I understand it is my responsibility, if I desire to do so, to cancel my current coverage, if any, by notifying the Provider or Plan Administrator of such coverage.

FRAUD WARNING

California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.

Fraud Warning:
AR, CO, KY, LA, ME, NM, OH, OK, TN and WA Residents: Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a crime and may be subject to fines or confinement in prison.

MD Residents: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. FRD1000A.MD.

DC Residents: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

NJ Residents: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

PA Residents: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

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Release of Information:
By joining this medical 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 on this form, I will be disenrolled.

I understand that my signature (or that of the person authorized to act on my behalf under State law where I live) on this application means that I have read and understand the contents of this application. If signed by an authorized individual, this signature certifies that this person is authorized under State law to complete this enrollment and documentation of this authority is available upon request by Medicare.

I understand that my signature (or the signature of the person authorized to act on my behalf under State law where I live) on this form means that I have read and understand the contents of the coverage document.

Date:	**Retiree Signature:**
Date:	**Spouse/Surviving Spouse Signature:**

If you are an authorized representative, you must sign above and provide the following information:
Name:____

Address:____

Phone Number:____

Relationship to Retiree:_________________________________

Please return signed election form to:
AmWINS Group Benefits
50 Whitecap Drive, North Kingstown, RI 02852

For Customer Service, please call: 1-888-883-3757
Monday through Friday, 8:00 AM to 8:00 PM EST