RETIREE MEDICAL INSURANCE PLAN ELECTION FORM

Medical plan is underwritten by: Transamerica 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
Columbus McKinnon Retiree 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

Retiree RxCare Medicare Prescription Drug Plan

Enrollment Form

Please contact Retiree RxCare if you need information in another language or format (Braille).

To enroll in Retiree RxCare, please provide the following Information and sign the last page of this form.

COLUMBUS MCKINNON **EFFECTIVE DATE:** ___________

Retiree		
Name:	Gender: ☐ M ☐ F	Birth Date:
Street Address:		
City:	State:	Zip:
Social Security Number:	Phone Number:	
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:		
Spouse or Surviving Spouse		
Name:	Gender: ☐ M ☐ F	Birth Date:
Street Address:		
City:	State:	Zip:
Social Security Number:	Phone Number:	
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:		
Alternative Contact (Optional)		
Name:		
Phone Number:	Relationship to you:	
Select Your Enrollment Options Below (Please Check Desired Coverage)		
Please check which plan you want to enroll in:		

Retiree	**Spouse or Surviving Spouse:**
☐ CMCO Custom 3 Tier	☐ CMCO Custom 3 Tier

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Please Answer the Following Questions to Help Medicare Coordinate Your Benefits:

1. Some individuals may have other drug coverage, including other private insurance, TRICARE, Federal employee health benefits coverage, VA benefits, or State pharmaceutical assistance programs.

Will you have other prescription drug coverage in addition to Retiree RxCare? ☐ Yes ☐ No

If "yes:, please list your other coverage and your identification (ID) number(s) for this coverage below:

Name of other coverage:	ID # for this coverage:	Group # for this coverage:

2. Are you a resident in a long-term care facility, such as a nursing home? ☐ Yes ☐ No

If "yes", please provide the following information:

Name of Institution:

Address (number and street) & Phone Number of Institution:

Please check one of the boxes below if you would prefer that we send you information in a language other than English or in another format:

_____ Over the phone interpretation service for multiple languages are available by calling 1-855-693-3921

_____ Large Print _____ Braille _____ Spanish _____ Portuguese

Please contact Retiree RxCare at 1-855-693-3921 if you need information in another format or language than what is listed above. TTY users should call 1-855-693-3921. Our office hours are 8:00 AM to 8:00 PM (EST), Monday through Friday.

Please Read This Important Information:

If you are a member of a Medicare Advantage Plan (like an HMO or PPO), you may already have prescription drug coverage from you Medicare Advantage Plan that will meet your needs. By joining Retiree RxCare, your membership in your Medicare Advantage Plan may end. This will affect your doctor and hospital coverage as well as your prescription drug coverage. Read the information that your Medicare Advantage Plan sends you and if you have questions, contact your Medicare Advantage Plan.

Retiree RxCare is offered through your employer or union. You could lose your employer or union health coverage if you join another Medicare Part D plan. Read the communications your employer or union sends you. If you have questions, visit their website, or contact the office listed in their communications. If there isn't information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help

Please Read This Important Information and Sign Below:

By completing this enrollment application, I agree to the following:

Retiree RxCare is a Medicare drug plan and has a contract with the Federal government. I understand that this prescription drug coverage is in addition to my coverage under Medicare; therefore, I will need to keep my Medicare Part A or Part B coverage. It is my responsibility to inform Retiree RxCare of any prescription drug coverage I have or may get in the future. I can only be in one Medicare prescription drug plan at a time – if I am currently in a Medicare Prescription Drug Plan my enrollment in Retiree RxCare will end that enrollment. Enrollment in this plan is generally for the entire year. Once I enroll, I may leave this plan or make changes if an enrollment period is available, generally during the Annual Enrollment Period (October 15 – December 7), unless I qualify for certain special circumstances.

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Retiree RxCare is a nationwide Medicare Part D plan. If I move out of the area Retiree RxCare serves, I need to notify the plan so I can disenroll and find a new plan in my new area. I understand that I must use network pharmacies except in an emergency when I cannot reasonably use Retiree RxCare network pharmacies. Once I am a member of Retiree RxCare, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from Retiree RxCare when I get it to know which rules I must follow to get coverage.

I understand that if I leave this plan and don't have or get other Medicare prescription drug coverage or creditable prescription drug coverage (as good as Medicare's), I may have to pay a late enrollment penalty in addition to my premium for Medicare prescription drug coverage in the future.

I understand that if I am getting assistance form a sales agent, broker, or other individual employed by or contracted with Retiree RxCare, he/she may be paid based on my enrollment in Retiree RxCare.

Counseling services may be available in my state to provide advice concerning Medicare supplement insurance or other Medicare Advantage or Prescription Drug Plan options, medical assistance through the state Medicaid program, and the Medicare Savings Program.

Release of Information:

By joining this Medicare prescription drug plan, I acknowledge that Retiree RxCare will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that Retiree RxCare will release my information, including my prescription drug event data, to Medicare, who may release it for research and other purposes which follow all applicable Federal statutes and regulations. 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 form the plan.

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 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 Medicare.

Retiree's Signature:	**Today's Date:**
Spouse or Surviving Spouse's Signature:	**Today's Date:**

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

Name:

Address:

Phone Number:

Relationship to Enrollee:

Medicare Prescription Drug Use Only:

Plan ID#

Effective Date of Coverage:	IEP:	AEP:	SEP (type):

Plan Representative Signature: