



Group Retiree Health Insurance Mandatory Plan Enrollment Form

Hartford Life & Accident Insurance Company

Policy Numbers: See Below

Policyholder: **TRUSTEES OF BENISTAR EMPLOYER SERVICES TRUST**

Participating Firm: United Pentecostal Church International (UPCI)

Please print clearly in ink or type

Retiree/Minister's Name: _____
First Middle Last

Street: _____

City, State, Zip: _____ Medicare ID # _____

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? _____

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

Gender ☐ Male ☐ Female Date of Birth _____ Social Security # _____

Medicare ID # _____ 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, if enrolling, have any other health insurance including an employer health plan? **Retiree/Minister** ☐ 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, intend to replace these medical or health policies with this policy or certificate? **Retiree/Minister** ☐ 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?

- ☐ Additional Benefits ☐ No change in benefits, but lower premiums
☐ Fewer benefits and lower premiums ☐ Other (please specify)
☐ Integration with Medicare

3. Are you covered by Medicaid?

Retiree/Minister ☐ Yes ☐ No **Dependent Spouse** ☐ Yes ☐ No

Please Check Desired Medical Plan To Enroll:

	Plan 1 (AGP-7083)	Plan 2 (AGP-7055)	Plan 3 (AGP-7085)
Retiree/Minister			
Dependent Spouse			

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

Benistar – Eligibility Dept.
10 Tower Lane, Suite 100
Avon, CT 06001

Email: memelig@benistar.com

Senior Medical Customer Service Number: 1-800-236-4782

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/Minister Signature: _____

Date: _____ Dependent Spouse Signature: _____
(if enrolling)