



| Group Retiree Insurance Plan Enrollment Form Hartford Life & Accident Insurance Company Policyholder: DALRC Retiree Benefit Trust Policy Numbers: AGP-4601, AGP -4466 | | | | | | |
|---|---|--------------------|---------------------------|-------------------------------|------------------|--|
| Please print clear | y in ink or type | | | | | |
| Delta Retiree's Nar | ne: | | | | | |
| | First | Middle | e | Last | | |
| Medicare # (on Me | edicare Card): | | | ck if waiting for N | Medicare # | |
| Phone Number: | | _ Address: | | | | |
| City | State | Zip code | Email addre | ess | | |
| Gender: 🗌 M 🔲 F | Date of Birth: | | Social Security | #: | | |
| Retirement Date: _ | Ha | ave you enrolled i | n Medicare Part I | B? 🗌 Ye | s 🗌 No | |
| Spouse/Surviving S | Spouse Name (if enrolling | g): | | | | |
| | | First | | Last | | |
| | Date of Birth | | Social Security | # | | |
| Medicare # (on Me | edicare Card): | | _Retirement Dat | te: | | |
| Has the spouse/su | rviving spouse enrolled ir | n Medicare Part B | ? | | s 🗌 No | |
| employer health | [or your dependent spou n plan? ich company? Please ind | Spo | • | Retiree 🗌 Ye | s 🗌 No | |
| Person Covered | Company Name | Policy | Type of | Effective | Expiration | |
| | | Number | Policy | Date | Date | |
| | | | | | | |
| | swer to question 1 is YE th policies with this policy | | | •• <u> </u> | blace these s | |
| | | Spe | ouse/Surviving | Spouse 🗌 Ye | s 🗌 No | |
| | to question 2 is NO and be aware this Group Ret | | | | | |
| | or your dependent spou Pharmaceutical Assist | | | cription drug co Retiree | | |
| If YES, please list of | other coverage and your i | • | ouse/Surviving ber(s): | Spouse 🗌 Ye | s 🗌 No | |
| Name of Coverage | | ID# for Cover | <u>```</u> | Group # for Co | overage | |
| | | | | | | |
| 4. Are you | covered by Medicaid? | S | pouse/Surviving | Retiree 🗌 Yes Spouse 🗌 Yes | | |
| Release of Inform | ation: | | | | | |

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 Signatur | e: _ |
|----------------------------------|-------------|
| (Required if enrolling) | |

_____ Date: _____

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.

| Delta subsidy is applied. | | | | |
|---------------------------------------|------------------------------------|-----------------------------------|-------------------------------------|--|
| Please change my | 2010 Monthly Premium* | | | |
| medical/prescription plan to: | | | | |
| Medical with Emerald Rx Plan | Plan A | Plan | Plan D | |
| Retiree | □ \$235.81 (WAX1, RM01) | | \$275.81 (WDX1, RM01, ED91) | |
| Retiree & Spouse | □ \$471.62 (WAX1, WAX5, RM02) | □ \$551.62 (WDX1, WD2 | □ \$551.62 (WDX1, WDX5, RM02, ED92) | |
| Spouse/Surviving Spouse | \$235.81 (WAX5, RM05,) | | \$275.81 (WDX5, RM05, ED95) | |
| Medical with Opal Rx Plan | Plan A | Plan D | | |
| Retiree | \$148.78 (WAX1, RM11) | □ \$188.78 (WDX1, RM ² | □ \$188.78 (WDX1, RM11) | |
| Retiree & Spouse | \$287.56 (WAX1, WAX5, RM12) | S377.56 (WDX1, WD2 | X5, RM12) | |
| Spouse/Surviving Spouse | □ \$148.78 (WAX5, RM15) | □ \$188.78 (WDX5, RM ² | 15) | |
| Provided at no additional premiu | m with your Medical/Prescription P | an: | | |
| - Hea | alth Advocate | | | |
| | ntity Protection Support Service | | | |
| | vel Assistance Program | | | |
| - Est | ateGuidance On-Line Will Preparat | ion | | |
| - Hea | aring Service Discount Plan | | | |
| *Monthly premium rate reflects your c | | | | |
| ** When enrolling in the Medical/Rx p | | | | |
| Vision Plan Information – Cheo | k the appropriate box. | | | |
| □ Retire | | | \$6.06 | |
| | e & Spouse (V002) | | \$11.45 | |
| Spous | e only/Surviving Spouse (V005) | | \$6.06 | |
| Dental Plan Information - Chec | k the appropriate box. | | | |
| Retiree | (D401) | | \$40.53 | |
| | & Spouse (D402) | | \$81.82 | |
| | e only/Surviving Spouse (D405) | | \$40.53 | |
| □ Retiree | | | \$21.33 | |
| | & Spouse (D002) | | \$42.46 | |
| | | | | |

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 <u>www.DALRCbenefitplans.com</u>

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 <u>www.socialsecurity.gov</u> (click on Medicare" then "Learn about getting help with prescription drug costs"), or
- Apply at your State Medical Assistance (Medicaid) office