RETIREE MEDICAL PLAN ELECTION FORM

CSDA

Medical Plan is Underwritten by: United American 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		Sex	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	
Sex		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: {effective_date} **Check Desired Coverage:**	**Retiree Only**	**Retiree & Spouse**	**Surviving Spouse**
Medical Plan:			

Please sign and date the next page

(continued on reverse)

RETIREE MEDICAL PLAN ELECTION FORM

Please sign and date below:	
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: 1.800.828.CSDA (2732)
Monday through Friday, 8:00 AM to 8:00 PM EST

MEDICARE PRESCRIPTION DRUG PLAN INDIVIDUAL ENROLLMENT FORM
EMPLOYER-SPONSORED GROUP PLAN

To enroll in Express Scripts Medicare® (PDP)
please provide the following information:

CSDA **Desired Effective Date: {effective_date}**

Retiree		
Last Name:	First Name:	Middle Initial:
☐ Mr. ☐ Mrs. ☐ Ms.	Birth Date: (__ __/__ __/__ __ __ __) (M M / D D / Y Y Y Y)	
Sex: ☐ M ☐ F	Social Security Number:	
Home Phone Number: ( )	E-Mail Address:	
Permanent Resident Street Address:		
City:	State:	ZIP Code:

Mailing Address (only if different from your Permanent Residence Address):			
Street Address:	City:	State:	ZIP Code:

Spouse or Surviving Spouse		
Last Name:	First Name:	Middle Initial:
☐ Mr. ☐ Mrs. ☐ Ms.	Birth Date: (__ __/__ __/__ __ __ __) (M M / D D / Y Y Y Y)	
Sex: ☐ M ☐ F	Social Security Number:	
Home Phone Number: ( )	E-Mail Address:	
Permanent Resident Street Address:		
City:	State:	ZIP Code:

Mailing Address (only if different from your Permanent Residence Address):			
Street Address:	City:	State:	ZIP Code:

Emergency Contact: (Optional)	
Name:	
Phone Number:	Relationship to you:
E-Mail Address:	

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Please Provide Your Medicare Insurance Information

Please take out your Medicare Card to complete this section.

- Please fill in these blanks so they match your red, white and blue Medicare card.
  - OR -
- Attach a copy of your Medicare card or your letter from the Social Security Administration or Railroad Retirement Board.

You must have Medicare Part A or Part B (or both) to join a Medicare prescription drug plan.

Retiree:	Spouse or Surviving Spouse:
SAMPLE ONLY	SAMPLE ONLY
Name: ______________________________	Name: ______________________________
Medicare Claim Number	**Medicare Claim Number**
__ __ __ - __ __ - __ __ __ __ ___ Sex ____	__ __ __ - __ __ - __ __ __ __ ___ Sex ____
Is Entitled To **Effective Date**	**Is Entitled To** **Effective Date**
HOSPITAL (Part A) ____________	HOSPITAL (Part A) ____________
MEDICAL (Part B) ____________	MEDICAL (Part B) ____________

Select Your Enrollment Options Below (Please Check Desired Coverage)

Please check which plan you want to enroll in:

Retiree:	Spouse or Surviving Spouse:

Important Information About Your Medicare Part D Prescription Drug Plan

Express Scripts Medicare® (PDP) is offered by Medco Containment Life Insurance Company, which contracts with the Federal government. This coverage is Medicare Part D coverage and is in addition to your coverage under Medicare Parts A and B. You must keep your Medicare Parts A and/or B coverage in order to qualify for this plan. You must inform your former employer of any other prescription drug coverage you may have.

Enrollment Requirements

You can be in only one Medicare prescription drug plan at a time. If you are currently in a Medicare prescription drug plan, a Medicare Advantage Plan with prescription drug coverage, or an individual Medicare Advantage Plan, your enrollment in Express Scripts Medicare may end that enrollment.

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Important Information About Your Medicare Part D Prescription Drug Plan

You must live within the 50 U.S. states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, Guam, the Northern Mariana Islands or American Samoa, and be a U.S. citizen or lawfully present in the United States to participate in this plan. It is your responsibility to inform your former employer of any address changes.

You can join a new Medicare prescription drug plan or Medicare health plan from October 15 to December 7. Except in special cases, you cannot join a new plan at any other time of the year. If you leave this plan and don't have or get other Medicare prescription drug coverage or creditable coverage (as good as Medicare's), you may be required to pay a late enrollment penalty (LEP) if you go 63 days or more without Medicare Part D coverage or other creditable prescription drug coverage.

Some people may have to pay an extra premium amount because of their yearly income. If you have to pay an extra amount, the Social Security Administration – not your Medicare plan – will send you a letter telling you what that extra amount will be and how to pay it. If you have any questions about this extra amount, contact the Social Security Administration at 1.800.772.1213. TTY users call 1.800.325.0778.

Medicare beneficiaries with low or limited income and resources may qualify for Extra Help. If you qualify, your Medicare prescription drug plan costs will be less. Once you are enrolled in this drug plan, Medicare will tell the plan how much assistance you will receive and Express Scripts will send you information on the amount you will pay. If you are not currently receiving Extra Help, you can contact 1.800.MEDICARE (1.800.633.4227) to see if you might qualify. TTY users call 1.877.486.2048.

Once you are a member of this plan, you have the right to file a grievance or appeal plan decisions about payment or services if you disagree. Read your *Evidence of Coverage* to know which rules you must follow to receive coverage with this Medicare prescription drug plan.

This information is not a complete description of benefits. Contact Express Scripts Medicare for more information. Limitations, copayments and restrictions may apply. Benefits, premium (if applicable) and/or copayments/coinsurance may change on January 1 of each year. The formulary and/or pharmacy network may change at any time. You will receive notice when necessary.

Release of Information:

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

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

Express Scripts Medicare (PDP) is a prescription drug plan with a Medicare contract.
Enrollment in Express Scripts Medicare depends on contract renewal.
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