Seniors Choice
Group Retiree Medical & Rx
Enrollment form

Underwritten by:
G·T·L
Guarantee Trust Life Insurance Company

Offered through the Merchants Industry Fund Group Insurance Trust

Section 1 – *Enrollee Information*

Enrollee Name: _____
First MI Last

Street Address: _____

City, State, Zip: _____

Telephone#: (___)_____ **SSN:** _____

Medicare # (HIC#): _____ **Date of Birth:** _____/_____/_____

Email: _____ **Sex:** ☐ Male ☐ Female

Section 2 – *Sponsoring Entity Information*

Sponsoring Entity Name: Kentucky Retired Teachers Association

Are you currently employed by your sponsoring entity? ☐ Yes ☐ No

If Yes: ☐ Full-Time ☐ Part-Time **If No**: ☐ Retired ☐ Spouse ☐ Other

Section 3 – *Current Coverage Information*

Do you have Medicare Part B coverage? ☐ Yes ☐ No
(You must have Part B coverage effective on or before the requested effective date.)

Are you currently covered under any employer/union provided group medical plan, Medicare Supplement Plan, or Medicare Advantage Plan? ☐ Yes ☐ No
(If yes, in order to be eligible for Seniors Choice you must terminate this coverage on or before the requested effective date.)

Are you currently enrolled in a Prescription Drug Plan? ☐ Yes ☐ No

If yes, Plan Type:

☐ Medicare Part D ☐ Discount Drug Plan Carrier Name: _____
☐ Medicare Advantage PDP ☐ Employer/Union Group Plan Plan Name: _____

Section 4 – *Seniors Choice Medical & Prescription Plan Selection*

You can only enroll in a medical or prescription plan that has been elected by your sponsoring entity.

Requested Effective Date: _____

☐ Medical & Prescription ☐ Medical Only ☐ Prescription Only

Medical Plan Selection:

☐ $0 Deductible Plan ☐ $500 Deductible Plan ☐ $2000 Deductible Plan
☐ $100 Deductible Plan ☐ $750 Deductible Plan ☐ $2500 Deductible Plan
☐ $150 Deductible Plan ☐ $1000 Deductible Plan ☐ $3000 Deductible Plan
☐ $250 Deductible Plan ☐ $1500 Deductible Plan ☐ $4000 Deductible Plan

Prescription Plan Selection: *(You must be retired or part-time to enroll.)*

☐ Choice Prescription Drug Plan ☐ Preferred Prescription Drug Plan ☐ Premier Prescription Drug Plan

mba merchants benefit admin
227 Rolling Ridge Way
Simpsonville, KY 40067
Humana.

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Terms and Conditions of Enrollment:

Seniors Choice is not a Medicare Supplement Plan. Seniors Choice is an Employer Group Retiree Medical Plan that coordinates with Medicare. You must be age 65 or over and be enrolled in Medicare Parts A & B to participate in this program. If you have a Medicare Supplement plan, you may not need both the Medicare Supplement plan and the Seniors Choice Employer Group Retiree Program.
On behalf of myself, and my eligible dependents, I am requesting enrollment under the Senior Choice Plans offered through my former (or current TEFRA eligible) employer. By signing this enrollment form, I agree to and understand the following:

1) **Medical Coverage**: Subject to the terms and conditions of the GTL Master Policy.
2) **Medical Coverage**: GTL or its designee shall have access to and use of me and my dependents medical records for purposes of utilization review, processing claims, financial audit or other purposes reasonably related to the performance of this Enrollment form.
3) **Medical Coverage**: Do not cancel existing medical coverage until approved in writing by MBA, Inc. During the time that you are covered by an employer's health plan that is primary to Medicare, the Seniors Choice plan will not provide coverage.
4) **Prescription Coverage:** Is provided by Humana. The Medicare Prescription Drug Coverage is provided by Humana Medicare Prescription Drug Plan which is a creditable Part D Plan as governed by CMS.
5) **Prescription Coverage:** By joining this Medicare Prescription Drug Plan, I acknowledge that Humana Medicare Prescription Drug Plan will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that Humana Medicare Prescription Drug Plan will release my information, including my prescription drug event date, to Medicare, who may release it for research and other purposes which follow all applicable Federal statutes and regulations.
6) **The Seniors Choice Prescription Drug Plan** is a Medicare drug plan and is in addition to my coverage under Medicare; therefore, I will need to keep my Medicare coverage. It is my responsibility to inform the Seniors Choice Prescription Drug Plan of any prescription drug coverage that 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 the Seniors Choice Prescription Drug Plan will end that enrollment. Enrollment in this plan is generally for the entire year. I may leave this plan only at certain times of the year, or under certain special circumstances, by sending a request to:
    a. The Seniors Choice Prescription Drug Plan or by calling 1-800-Medicare, 24 hours per day, 7 days per week.
    b. TTY users should call 1-877-486-2048. Final approval of the effective date of enrollment is determined by CMS.
7) **Prescription Coverage**: I understand that if I leave this plan and do not have or obtain other Medicare prescription drug coverage or creditable 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.
8) **Prescription Coverage**: Once I am a member of Humana Medicare Prescription Drug Plan, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from Humana Medicare Prescription Drug Plan when I receive it to know which rules I must follow in order to receive coverage with this Medicare drug plan.
9) 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 dis-enrolled from the plan.
10) I understand that my signature (or the 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:
    a. This person is authorized under State law to complete this enrollment and
    b. Documentation of this authority is available upon request by the Seniors Choice Prescription Drug Plan or by Medicare.
11) 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.
12) A retiree or the dependent spouse or domestic partner of a retiree must: (a) be age 65 or older, (b) be covered under Medicare Parts A and B, (c) not be eligible for Medicaid, (d) not be covered under a Medicare Supplement policy or certificate, (e) not be covered by an employer's health plan which is primary to Medicare due to employment of such person, and (f) not be confined to a Hospital or Skilled Nursing Home on the effective date of coverage. If a retiree or dependent spouse is confined to a Hospital or Skilled Nursing Home on the effective date of coverage, coverage will be delayed until the day after the date of release from the Hospital or Skilled Nursing Home.

Enrollee Signature: _____ Date: _____

For more information, contact The Kentucky Retired Teachers Association at (502) 643-8739 or email randall_childers@me.com

Medical Coverage Underwritten By:
Guarantee Trust Life Insurance Company

Administered By:
MBA, Inc

Prescription Coverage Provided by:
Humana Insurance Company

Seniors Choice Payment Authorization Form

Return this form to: Fax (480) 776-5050 or email: memberservices@mbaadmin.com

INSURED INFORMATION	
TODAY'S DATE:	
NAME OF INSURED:	
EMAIL ADDRESS:	
POLICY ID NUMBER:	
DATE TO BEGIN*:	
***Payment will be taken on the 1st of every month**	

I would like to pay by: ☐ EFT ☐ CREDIT CARD

AUTHORIZATION AGREEMENT FOR ELECTRONIC FUND TRANSFER	
NAME ON BANK ACCOUNT:	
NAME OF BANK:	
BANK ACCOUNT NUMBER:	
BANK ROUTING NUMBER:	
TYPE OF ACCOUNT:	☐ SAVINGS ☐ CHECKING
Please include a copy of a voided check or savings deposit slip	

AUTHORIZATION FOR CREDIT CARD PAYMENT	
CHARGE MY CREDIT CARD:	☐ Visa ☐ MasterCard ☐ Discover ☐ American Express
CREDIT CARD NUMBER:	
CREDIT CARD EXP DATE:	
NAME ON CREDIT CARD:	
CARD BILLING ADDRESS:	

DEDUCTION AUTHORIZATION: I hereby authorize the insurance premiums to be deducted and remitted to Merchants Benefit Administration. This authority is to remain in effect until I cancel it by written notification to Merchants Benefit Administration at least 30 days in advance of the intended termination date of my coverage. (Any excess premiums which may accrue after termination of my coverage will be refunded to me.) There will be a $15.00 fee associated with an insufficient funds notification.

_____ _____

ACCOUNT HOLDER SIGNATURE DATE (MM/DD/YYYY)

Questions?

Please call (888) 538-9333

mba merchants benefit admin

MBA, Inc. 15974 N 77th St Suite 102, Scottsdale, AZ 85260 Fax: (480) 776-5050