Public School Retirement System
of the City of St. Louis

Benefit Enrollment Form

Section 1: Personal Information

Your Name:	Sex: Male ☐ Female ☐
Street Address:	Marital Status:
Address 2:	Birth Date:
City:	Cell Phone:
State: Zip:	Home Phone:
Soc. Sec. No.: Last 4 digits:	
Email:	

Section 2: Reason, Effective Date, Plan Selection

Why? ◯ New Retiree ◯ Involuntary Coverage Loss ◯ OE Plan Change ◯ Medicare Eligibility
◯ Other Reason ____

When? ____

What?

UnitedHealthcare®
- ◯ Base - Commercial
- ◯ Buy-Up - Commercial
- ◯ Low - Medicare Advantage
- ◯ High - Medicare Advantage

- ◯ Retiree Only
- ◯ Retiree +

Delta Dental
- ◯ Low
- ◯ High

- ◯ Retiree Only
- ◯ Retiree +

EyeMed
- ◯ Retiree Only
- ◯ Retiree +

MetLife Legal Aid
- ◯ Retiree +

AllState Identity Theft Protection
- ◯ Retiree Only
- ◯ Retiree +

Section 3: Medicare Information

_____ Yes _____ No Have you had continuous creditable coverage since becoming Medicare eligible?

_____ Yes _____ No Are you a resident of a long term care facility?

_____ Yes _____ No Do you have End Stage Renal Disease (ESRD)?

_____ Yes _____ No Did you become eligible for Medicare because you were diagnosed with End Stage Rental Disease and has it been less than 30 months since you became eligible?

_____ Yes _____ No Are you enrolled in your state Medicaid Program? If yes, provide your Medicaid number:

____

MEDICARE HEALTH INSURANCE

Name/Nombre

Medicare Number/Número de Medicare

Entitled to/Con derecho a

HOSPITAL (PART A)

MEDICAL (PART B)

Coverage starts/Cobertura empieza

I request enrollment in the PSRSSTL sponsored plans for myself and dependents as selected in Section 1. I authorize PSRSSTL to deduct the amount necessary to cover premiums from my PSRSSTL retirement benefit. This may include any catch up deductions. I understand that to cancel coverage, I must submit request to the PSRSSTL Insurance Specialist prior to the cancellation date and premiums cannot be refunded retroactively. All coverage is subject to the Insurance policies available from each insurance provider.

Retiree Signature: ______________________________ Date: ______________

Dependent Signature: ______________________________ Date: ______________

Dependent Signature: ______________________________ Date: ______________

Section 4: Dependents

Do you have other prescription drug coverage (including private insurance, workers' compensation, VA benefits or through the State Pharmaceutical Assistance Program? If yes, please complete the following:

Name of other coverage: ______________________________ ID No.: _________________ Group No.: ____________________

Dependent Sex: Male ☐ Female ☐

Name:	Relationship:
Soc. Sec. No.:	Date of Birth:

_____ Yes _____ No Have you had continuous creditable coverage since becoming Medicare eligible?

_____ Yes _____ No Are you a resident of a long term care facility?

_____ Yes _____ No Do you have End Stage Renal Disease?

_____ Yes _____ No Did you become eligible for Medicare because you were diagnosed with End Stage Rental Disease and has it been less than 30 months since you became eligible?

_____ Yes _____ No Are you enrolled in your state Medicaid Program? If yes, provide your Medicaid number:

____

Name/Nombre

Medicare Number/Número de Medicare

Entitled to/Con derecho a

HOSPITAL (PART A)

MEDICAL (PART B)

Coverage starts/Cobertura empieza

Agreement: Please read the following carefully

1. I apply for membership in UnitedHealthcare® for myself and for any eligible dependents listed. I authorize PSRSSTL to make deductions for the premiums.
2. I and my eligible dependents shall abide by the provisions of coverage in the UnitedHealthcare® Enrollment agreement, Certificate of Coverage and Benefit Riders under which we are enrolled.
3. By signing this form, I authorize the Public School Retirement System and any physician, hospital, medical group or other facility providing me care, treatment or consultation, to disclose to UnitedHealthcare®, or receive from UnitedHealthcare®, any medical or claim information pertaining to the persons identified in this enrollment form receiving coverage under this plan, as may be necessary to enable UnitedHealthcare® to make coverage determinations, pay claims or otherwise administer plan programs, including without limitation, credentialing of physicians and as applicable, other providers, all of which shall be conducted in accordance with state and federal confidentiality laws. UnitedHealthcare® will not disclose any information pertaining to HIV/AIDS or chemical dependency/substance abuse except as specifically permitted by applicable law.
4. I understand and agree no benefits shall take effect until this application is approved by UnitedHealthcare® and, if applicable, Medicare.
5. I understand that my membership may be cancelled for one or both of the following reasons: 1) failure to pay the amount due under the UnitedHealthcare Enrollment Agreement or Certificate of Coverage, for which I am legally responsible, or (2) fraud or material misrepresentation in enrollment or in the use of services or facilities.
6. I understand that it is my responsibility to report to the Public School Retirement System any change in the eligibility of myself or my dependents. By signing this form, I certify ALL information given is true and accurate. By enrolling in one of the UnitedHealthcare® Group Medicare Advantage PPO Plans, I agree to the following: This is a Medicare Advantage plan and has a contract with the federal government. This is not a Medicare Supplement plan. I need to keep my Medicare Part A and Part B, and continue to pay my Medicare Part B and, if applicable, Part A premiums, if they are not paid for by Medicaid or a third party. I can only have one Medicare Advantage or Prescription Drug plan at a time.

- Enrolling in this plan will automatically dis-enroll me from any other Medicare health plan. If I dis-enroll from this plan, I will be automatically transferred to Original Medicare. If I enroll in a different Medicare Advantage plan or Medicare Part D Prescription Drug Plan, I will be automatically disenrolled from this plan.
- If I have prescription drug coverage or if I get prescription drug coverage from somewhere other than this plan, I will inform UnitedHealthcare®.
- Enrollment in this plan is for the entire plan year. I may leave this plan only at certain times of the year or under special conditions. If I do not have prescription drug coverage, I may have to pay a late enrollment penalty. This would apply if I did not sign up for and maintain creditable prescription drug coverage when I first became eligible for Medicare. If I get a late enrollment penalty, I will receive a letter making me aware of the penalty and what the next steps are. The service area includes the 50 United States, the District of Columbia and all U.S. territories. I may not be covered while out of the country, except for limited coverage near the U.S. border. However, under this plan, when I am outside of the U.S., I am covered for emergency or urgently needed care. I will get a Plan Details book that includes an Evidence of Coverage (EOC).
- The EOC will have more information about services covered by this plan. If a service is not listed, it will not be paid for by Medicare or this plan without authorization.
- I have the right to appeal plan decisions about payment or services if I do not agree.My information will be released to Medicare and other plans, only as necessary, for treatment, payment and health care operations. Medicare may also release my information for research and other purposes that follow all applicable Federal statutes and regulations. The Formulary, pharmacy network, and/or provider network may change at any time. You will receive notice when necessary. Plans are insured through UnitedHealthcare® Insurance Company or one of its affiliated companies, a Medicare Advantage organization with a Medicare contract and a Medicare-approved Part D sponsor. Enrollment in the plan depends on the plan's contract renewal with Medicare. You must continue to pay your Medicare Part B premium. Out-of-network/non-contracted providers are under no obligation to treat UnitedHealthcare® members, except in emergency situations. Please call our customer service number (1-844-876-6160) or see your Evidence of Coverage for more information. By enrolling in the Delta Dental Plan, I understand: 1) that there may be instances where treatment decisions made by my dentist or me or dental expenses which I have incurred may not be covered by my dental plan; 2) that information collected in connection with administration of the benefit plan may be used to bring to my attention health products or services that might be valuable to me and otherwise as permitted by law; 3) that you may combine that information with other information so that it is no longer individually identifiable and use it for commercial and other purposes. Any person who knowingly and with intent to injure, defraud or deceive any insurer, files a statement or an application containing any false, incomplete or misleading information is guilt of a felony of the third degree. The Delta Dental Certificate provides dental benefits only. Review the Certificate of Coverage carefully. By signing this form, I certify ALL information given is complete, true and accurate. Pension Deduction Authorization: By signing this application, member authorizes the Public School Retirement System to withhold insurance premiums for such coverage from member's monthly pension check. Monthly premiums for the available plans are determined annually by each respective insurance company. This authorization may not be withdrawn unless member cancels the coverage for which the premium deductions are authorized. By signing this application, member understands that some of the insurance companies impose restrictions on cancellations. Member also understands that he/she must notify the Public School Retirement System in writing in order to cancel coverage and withdraw this deduction authorization.

Upon form completion, email it to monica.brewer@psrsstl.org or drop it off at 3641 Olive Street, Saint Louis, MO 63108 in the drop box adjacent to the front door. Thank you.

Retiree Signature: Date:

Dependent Signature and Date below is only required if enrolling in a Medicare Advantage plan.