RETIREE MEDICAL & PRESCRIPTION DRUG PLAN ELECTION FORM

New York County Dental Society
Medical plan is underwritten by: Transamerica Financial Life Insurance Company, Harrison, NY

Your election form must be signed and returned PRIOR to your effective date 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: **Check Desired Coverage:**	**Retiree Only**	**Retiree & Spouse**	**Surviving Spouse**
Medical Plan Options:	☐**OPTION 1** ☐**OPTION 2**	☐**OPTION 1** ☐**OPTION 2**	☐**OPTION 1** ☐**OPTION 2**

(continued on reverse)

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Please Complete the Following Information:
Do you (or your spouse, if enrolling) currently have any Medicare Supplement policies or certificates in force (including Health Maintenance Organization contract or Health care service contract)?
Retiree (if enrolling): ☐ Yes ☐ No   Spouse (if enrolling): ☐Yes ☐No

a) If YES*, with which company? ____
b) What kind of policy / certificate? ____
c) Length of time you have had coverage? _______________________ Years__________ Months__________
d) Will you be replacing the above listed policy/certificate upon acceptance of this enrollment form?
   ☐ Yes ☐ No

*I understand it is my responsibility, if I desire to do so, to cancel my current coverage, if any, by notifying the Provider or Plan Administrator of such coverage.

FRAUD WARNING

Fraud Warning:
NY Residents: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

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RETIREE MEDICAL & PRESCRIPTION DRUG PLAN ELECTION FORM

Please Sign and Date:

I/We hereby enroll in the New York County Dental Society Retiree Medical Insurance Plan provided under group Policy Form number RM1000GETF issued by Transamerica Financial Life Insurance Company. I/We am/are 65 or over and covered by Medicare Parts A & B. I/We understand that in order to be eligible for this coverage, I/We must already have other comprehensive health coverage or an HMO. If I/We do not already have other comprehensive health coverage or an HMO, I/We am/are not eligible for this coverage. I/We understand this insurance will be effective on the date shown on the certificate schedule.

Release of Information:

By joining this medical and Medicare prescription drug 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 on this form, I will be disenrolled.

I understand that my signature (or that of the person authorized to act on my behalf under State law where I live) on this application means that I have read and understand the contents of this application. If signed by an authorized individual, this signature certifies that this person is authorized under State law to complete this enrollment and documentation of this authority is available upon request by Medicare.

I understand that my signature (or the signature of the person authorized to act on my behalf under State law where I live) on this form means that I have read and understand the contents of the Medicare GenerationRx (Employer PDP) Important Information about Your Prescription Drug Coverage document.

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: 1-844-796-3624
Monday through Friday, 8:00 AM to 8:00 PM EST

PRESCRIPTION DRUG PLAN

Enrollment Form for Plans Underwritten by Envision Insurance Company

Please provide the following information and sign the last page of this form.

New York County Dental Society

Retiree		
Name:	Gender: ☐ M ☐ F	Birth Date:
Street Address:		
City:	State:	Zip:
Social Security Number:	Phone Number:	
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:		
Spouse or Surviving Spouse		
Name:	Gender: ☐ M ☐ F	Birth Date:
Street Address:		
City:	State:	Zip:
Social Security Number:	Phone Number:	
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:		
Alternative Contact (Optional)		
Name:		
Phone Number:	Relationship to you:	
Select Your Enrollment Options Below (Please Check Desired Coverage)		
Please check which plan you want to enroll in:		
Retiree: ☐ Basic Medicare Part D (PDP0000) ☐ Enhanced Plan (ENH 01)	**Spouse or Surviving Spouse:** ☐ Basic Medicare Part D (PDP0000) ☐ Enhanced Plan (ENH 01)	

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Please Answer the Following Questions to Help Medicare Coordinate Your Benefits:

1. Some individuals may have other drug coverage, including other private insurance, TRICARE, Federal employee health benefits coverage, VA benefits, or State pharmaceutical assistance programs.

Will you have other prescription drug coverage in addition to Retiree RxCare? ☐ Yes ☐ No
If "yes:, please list your other coverage and your identification (ID) number(s) for this coverage below:

Name of other coverage:	ID # for this coverage:	Group # for this coverage:

2. Are you a resident in a long-term care facility, such as a nursing home? ☐ Yes ☐ No
If "yes", please provide the following information:

Name of Institution:

Address (number and street) & Phone Number of Institution:

Please Read This Important Information:

If you are a member of a Medicare Advantage Plan (like an HMO or PPO), you may already have a prescription drug benefit from your Medicare Advantage Plan that will meet your needs. By joining Retiree RxCare your membership in your Medicare Advantage Plan may end. This will affect both your doctor and hospital coverage as well as your prescription drug benefits. Read the information that your Medicare Advantage Plan sends you and if you have questions, contact your Medicare Advantage Plan.

If you currently have health coverage from another employer or union, i.e., through your spouse or another former employer, joining Retiree RxCare could affect your employer or union health benefits. If you have health coverage from another employer or union, and you enroll in Retiree RxCare, we may coordinate the benefits between your other plan and Retiree RxCare. Read the communications your employer or union sends you. If you have questions, visit their website, or contact the office listed in their communications. If there is no information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

Please Read This Important Information and Sign Below:

By completing this enrollment application, I agree to the following:

Retiree RxCare (PDP) is a Medicare drug plan and is in addition to my coverage under Medicare; therefore, I will need to keep my Medicare Part A or Part B coverage. It is my responsibility to inform Heartland Fidelity Insurance Company 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 PDP 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 Heartland Fidelity Insurance Company or by calling 1-800-Medicare, 24 hours per day, 7 days per week. TTY users should call 1-877-486-2048.

Retiree RxCare is a national employer group so if I move out of state, I can remain enrolled in the plan. I will notify the Plan of my address change. Once I am a member of Retiree RxCare, I have the right to appeal plan decisions about payment or services with which I disagree. I will read the Evidence of Coverage document from Retiree RxCare when I receive it to know which rules I must follow in order to receive coverage with this Medicare drug plan.

Release of Information:	
By joining this Medicare prescription drug plan, I acknowledge that Heartland Fidelity Insurance Company will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that Heartland Fidelity Insurance Company will release my information, including my prescription drug event data, to Medicare, who may release it for research and other purposes which follow all applicable Federal statutes and regulations. 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 disenrolled from the plan. I understand that my signature (or the signature of the person authorized to act on my behalf under the laws of the State where I reside) 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 Heartland Fidelity Insurance Company or by Medicare.	
Retiree's Signature:	**Today's Date:**
Spouse or Surviving Spouse's Signature:	**Today's Date:**

Please complete this section: To the best of my knowledge, the information on this form is true and correct.	
Signature:	Date:

If you are the authorized representative, you must provide the following information:
Name:
Address:
Phone Number:
Relationship to Enrollee:

Medicare Prescription Drug Use Only:			
Plan ID#			
Effective Date of Coverage:	IEP:	AEP:	SEP (type):
Plan Representative Signature:			