Fermilab

# *Fermi Research Alliance (FRA)*
## *Medical Plan for Non-Medicare Eligible Retirees and Dependents*
## *Annual Enrollment Form*

| Fermi ID | Retiree Last Name | Retiree First Name | Middle Initial | Home email address \| Your Personal Email |
|---|---|---|---|---|
| | | | | |

| Street Address | City | State, Zip | Home Phone |
|---|---|---|---|
| | | | |

***Retiree Medical Coverage***

☐ Plan Change
- ☐ Blue Cross Blue Shield PPO
- ☐ Blue Cross Blue Shield Blue Advantage HMO

☐ Coverage Change
- ☐ Single
- ☐ Retiree + Child(ren)
- ☐ Retiree + Spouse
- ☐ Family

☐ No Change

BENEFITS OFFICE USE ONLY

Benefit Program RET Billing Effective Date _____ Payment Method ACH

| | | | |
|---|---|---|---|
| BPPORU (BCBS PPO No MCR) | 0200 (BCBS PPO No MCR) | 1 (Single) | 2 (Retiree + Spouse) |
| BLADRU (BCBS HMO no MCR) | 0200 (BCBS HMO No MCR | 3 (Retiree + Child(ren) | 4 (Family) |

**Please provide information below for yourself and your eligible dependents to be covered under the Fermilab Retiree Medical Plan**

| Name, Last/First/Middle Initial | Gender | Birth Date (mm/dd/yyyy) | Social Security Number (SSN is not required) | Blue Cross - HMO PCP Name | Blue Cross HMO – Medical Group Number (3 digits) |
|---|---|---|---|---|---|
| *Self* | | | not needed | | |
| *Spouse** | | | not needed | | |
| *Child ** | | | not needed | | |

☐ **I decline coverage** and I understand that I cannot elect coverage at a later date.

### Retiree Acknowledgements:

I understand that premiums for my retiree medical coverage will be automatically deducted from my bank account. Completion of an authorization agreement is required. I understand that my coverage will be terminated for non-payment of my premiums.

I understand that my coverage once terminated cannot be reinstated.

I understand that subject to the provisions of the Medicare Secondary Payer Act [42 U.S.C. §1395y (b) (2) (A) (ii) and the terms of the Fermi Research Alliance, LLC Medical Plan for Employees and Retirees, upon my retirement from Fermi Research Alliance, LLC, Medicare becomes the primary payer for all medical claims for me and my covered dependents who are eligible for Medicare. This includes retirees and dependents whose Medicare eligibility is due to age, disability or any other reason. I understand that if I or my covered dependent is eligible for Medicare, it is my responsibility to enroll in Medicare Parts A and B prior to my retirement, and to pay any required premiums. I further understand that the FRA medical plan has no responsibility to pay any medical expenses incurred by me or by my covered dependents for services for which Medicare would have paid except for my failure to timely enroll.

I have been provided a copy of the FRA Summary Plan Description for Active and Retired Employees in electronic format, and understand that if I wish to receive a hard copy, that one will be provided to me.

I understand that FRA reserves the right to amend, modify or terminate the plan at any time.

Signature _____ Date _____

Benefits Office Signature _____ Date _____