DMBA

RETIREE BENEFIT ENROLLMENT FORM

☐ New enrollment ☐ Mid-year change ☐ Open enrollment

RETIREE INFORMATION (REQUIRED–COMPLETE IN FULL)

Retiree name: _____ DMBA ID number: _____

Medicare number: _____ Social Security number: _____

Birth date (MM/DD/YYYY): _____ Phone: _____ Email: _____

Home address: _____

City: _____ State: _____ ZIP code: _____

Mailing address (if different): _____

City: _____ State: _____ ZIP code: _____

Marital status: ☐ Married ☐ Widowed ☐ Single ☐ Divorced Sex: ☐ Male ☐ Female

CHOOSING YOUR BENEFITS

CHOOSE WHO TO ENROLL:

☐ Myself ☐ Myself and one dependent ☐ Myself and two or more dependents

IF YOU OR YOUR DEPENDENTS ARE ELIGIBLE FOR MEDICARE, CHOOSE YOUR MEDICAL PLAN:

☐ Deseret Alliance ☐ Kaiser Senior Advantage California* ☐ Kaiser Senior Advantage Hawaii*

IF YOU OR YOUR DEPENDENTS ARE NOT ELIGIBLE FOR MEDICARE, CHOOSE YOUR MEDICAL PLAN:

Preferred Provider Organization: ☐ DMBA PPO 90 ☐ DMBA PPO 70 ☐ Deseret Choice Hawaii*

High Deductible Health Plan (HSA eligible): ☐ DMBA HSA 80+ ☐ DMBA HSA 60+

Outside Health Maintenance Organization: ☐ Kaiser of California* ☐ Kaiser of Hawaii*

* Plan availability based on location. If you choose Kaiser, please complete the appropriate Kaiser application for where you live.

+ For more information about HSA-eligible plans, see the attached document.

CHOOSE YOUR VISION PLAN:

☐ VSP *with* an annual eye exam ☐ VSP *without* an annual eye exam ☐ Waive vision

Check the box if you wish to waive medical benefits:

☐ I wish to waive medical benefits. (If you are eligible, you will retain your Retiree Group Term Life.) **I understand I may not apply for medical benefits later, except in certain circumstances.**

DEPENDENT INFORMATION

For dependent coverage, complete the following information. List your spouse and all legal dependents from oldest to youngest. **If you omit any dependents or don't add new dependents, they will not be covered**.

RELATIONSHIP TO RETIREE		NAME (FIRST, MIDDLE INITIAL, LAST)	BIRTH DATE (MM/DD/YYYY)	SEX	SOCIAL SECURITY NUMBER (REQUIRED)
S – Legal Spouse N – Natural or Adopted Child SC – Stepchild MC – Married Child GC – Grandchild O – Other (Specify in comments)				M F	
				M F	
				M F	
				M F	
				M F	
				M F	
				M F	
				M F	

OTHER MEDICAL COVERAGE

Are you or your dependents covered by any medical plan other than a DMBA plan? ☐ Yes ☐ No

If yes, provide the following information:

Other insurance carrier name: _____

Carrier address: _____

Carrier telephone number: _____

Policy holder name: _____

Policy number: _____

RETIREE AUTHORIZATION (REQUIRED)

☐ I wish to enroll or make changes as indicated on this form.

☐ I wish to waive or discontinue all benefits.

If waiving or discontinuing benefits, I understand the benefits of this program include medical coverage and Group Term Life. I choose not to participate in these benefits for myself and my dependents and hereby waive such coverage. **I also understand that in waiving this coverage, I am not eligible to enroll at a later date**.

If applying for benefits, by completing this enrollment application, I agree to the following:

- **PREMIUM DEDUCTION:** I hereby apply for the benefits specified and authorize the deduction of my portion of the premiums from my Master Retirement Plan benefit. If my Master Retirement Plan benefit is not large enough to cover the

premium, I'll be billed individually for this coverage and agree to pay the premium to DMBA. I understand the benefits of this program, including the various options and conditions given herein.

- **ELIGIBILITY REQUIREMENTS:** Because Deseret Alliance is a Medicare supplement plan, I must be properly enrolled in both Medicare Part A and Part B. In other words, I am covered by Medicare and I also receive Deseret Alliance benefits after Medicare pays. Medicare is my primary coverage and Deseret Alliance is my secondary coverage. I understand that while the plan is designed to work with Medicare Parts A and B, it is not intended to pay all amounts Medicare does not cover. Deseret Alliance is not a "Medigap" plan.
- **INFORMATION RELEASE:** The information on this enrollment form is correct to the best of my knowledge. If I intentionally provide false information on this form, I'll be disenrolled from the plan. My signature on this application (or the signature of the person authorized to act on my behalf under the laws of the state where I reside) means 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 DMBA or by Medicare.

If someone is signing this authorization on your behalf, documentation showing legal authority to do so (such as a power of attorney or guardianship) is required. Please attach a copy to this form before submission unless we have already received, reviewed, and approved this documentation. We cannot process your enrollment until we have the required documents on file.

I am the: ☐ Retiree ☐ Personal representative Relationship to retiree (if applicable): _____

Signature: _____ Date signed: _____

BENEFICIARY INFORMATION

To designate your primary and alternate beneficiaries for life benefits, complete a *Beneficiary Form* or log in to www.dmba.com.

COMMENTS

Please return this completed form to enrollmenthelp@dmba.com. You may also mail it to DMBA, Attention: Member Services, P.O. Box 45530, Salt Lake City, UT 84145-0530 or fax it to 801-578-5933. For questions, visit www.dmba.com or call us at 801-578-5600 or 800-777-3622.