DMBA

RETIREE BENEFIT ENROLLMENT FORM

☐ New enrollment ☐ Mid-year change ☐ Open enrollment

A. PERSONAL INFORMATION

Retiree name: _____ DMBA ID number: _____

Medicare number: _____ Social Security number: _____

Birth date: _____ Phone: _____ Email: _____

Home address: _____

City: _____ State: _____ ZIP code: _____

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

Mailing address (if different): _____

City: _____ State: _____ ZIP code: _____

B. 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 Hawaii (Complete the HMO application.)

☐ Kaiser Senior Advantage California (Complete the HMO application.)

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

☐ Deseret Premier ☐ Deseret Select (Available in parts of Utah and southeastern Idaho.) ☐ Deseret Value

☐ Deseret Protect ☐ Kaiser (If you choose Kaiser, complete the appropriate Kaiser application for where you live.)

CHOOSE YOUR VISION PLAN:

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

Check the box if you want life coverage only:

☐ Group Term Life only (waiver of medical and vision benefits)

I understand I may not apply for medical benefits later, except in certain circumstances.

C. RETIREE AUTHORIZATION

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, you must be properly enrolled in both Medicare Part A and Part B. In other words, you're covered by Medicare and you also receive Deseret Alliance benefits after Medicare pays. Medicare is your primary coverage and Deseret Alliance is your secondary coverage. But remember, 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.

Your name (please print): _____

Signature: _____ Date: _____

Your spouse's name (please print): _____

Signature: _____ Date: _____

If you are an authorized representative, provide the following information:

Name: _____

Address: _____

Telephone number: _____ Relationship to enrollee: _____

D. BENEFICIARY INFORMATION

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

E. WAIVER OF BENEFITS (SIGN *ONLY* IF YOU REJECT ALL 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**.

Your name (please print): _____

Signature: _____ Date: _____

F. 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 EMPLOYEE		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	

G. 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:

Carrier name: _____

Carrier address: _____

Carrier telephone number: _____

Policy holder: _____

Policy number: _____

H. COMMENTS

I hereby affirm the elections made in this form.

Retiree signature: _____ Date: _____

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