Medicare Supplement Insurance Enrollment Form

Hartford Life Insurance Company

Policy Numbers: AGP-3777

Policyholder: IBEW Local #332 Health & Welfare Plan

Please print clearly in ink or type

Retiree's Name: _____
First Middle Last

Street: _____

City, State, Zip: _____ Medicare # _____

Sex ☐ Male ☐ Female Date of Birth _____ Social Security # _____

Date of Retirement _____

Spouse's Name (Only if enrolling): _____
First Middle Last

Date of Birth _____ Social Security # _____

Medicare # _____ Date of Retirement _____

To the best of your knowledge:

1. Do you (or anyone proposed for coverage) have another Medicare Supplement policy or certificate in force including a health care service contract or health maintenance organization (HMO) contract? Retiree: ☐ Yes ☐ No Spouse: ☐ Yes ☐ No
   If so, with which company?

Covered Person	Company Name	Policy Number	Effective Date	Expiration Date

2. Do you or your spouse (if enrolling) have any other health insurance policies or certificates that provide benefits which this Medicare Supplement policy or certificate would duplicate?
   Retiree: ☐ ☐ Yes ☐ No Spouse: ☐ Yes ☐ No

   If so, with which company? What kind of policy? _____

Covered Person	Company Name	Policy Number	Kind of Policy	Effective Date	Expiration Date

3. If the answer to question 1 or 2 is yes, do you (or anyone proposed for coverage) intend to replace these medical or health policies with this policy or certificate? Retiree ☐ Yes ☐ No Spouse: ☐ ☐ Yes ☐ No

   If yes, for what reason are you (or anyone proposed for coverage) replacing the coverage?

   ☐ Additional Benefits
   ☐ Fewer benefits and lower premiums
   ☐ No change in benefits, but lower premiums
   ☑ Other (please specify)

4. Are you covered by Medicaid? Retiree ☐ Yes ☐ No Spouse: ☐ Yes ☐ No

5. Did you or your spouse first enroll in Medicare Part B within the last six (6) months?
   Retiree: ☐ ☐ Yes ☐ No Spouse: ☐ Yes ☐ No

Covered Person		
Medicare Part B Enrollment Date		

Note: If you or your spouse answered "Yes" to Question 5, do not answer questions 6 or 7 for that person.

6. Have you smoked cigarettes, cigars, or used pipe or chewing tobacco, nicotine chewing gum or snuff during the past 12 months? Retiree ☐ Yes ☐ No Spouse: ☐ Yes ☐ No

7. If you are enrolling your spouse for coverage, has he/she smoked cigarettes, cigars, or used pipe or chewing tobacco, nicotine chewing gum or snuff during the past 12 months?
   Retiree ☐ Yes ☐ No Spouse: ☐ Yes ☐ No

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PLEASE NOTE

1. YOU OR YOUR SPOUSE DO NOT NEED MORE THAN ONE SUPPLEMENT POLICY OR CERTIFICATE.
2. IF YOU OR YOUR SPOUSE ARE 65 YEARS OR OLDER, YOU HE/SHE MAY BE ELIGIBLE FOR BENEFITS UNDER MEDICAID AND MAY NOT NEED A MEDICARE SUPPLEMENT POLICY OR CERTIFICATE.
3. THE BENEFITS AND PREMIUMS UNDER YOUR OR YOUR SPOUSE'S MEDICARE SUPPLEMENT POLICY OR CERTIFICATE WILL BE SUSPENDED DURING YOUR HIS/HER ENTITLEMENT TO BENEFITS UNDER MEDICAID FOR 24 MONTHS. YOU HE/SHE MUST REQUEST THIS SUSPENSION WITHIN 90 DAYS OF BECOMING ELIGIBLE FOR MEDICAID. IF YOU HE/SHE ARE NO LONGER ENTITLED TO MEDICAID, THE POLICY WILL BE REINSTITUTED IF REQUESTED WITHIN 90 DAYS OF LOSING MEDICAID ELIGIBILITY.
4. COUNSELING SERVICES MAY BE AVAILABLE IN YOUR STATE TO PROVIDE ADVICE CONCERNING YOUR PURCHASE OF MEDICARE SUPPLEMENT INSURANCE AND CONCERNING MEDICAID.

✔ Please check desired coverage:

	Coverage	
Retiree	☐	
Spouse	☐	

Complete this form answering all questions. Please be sure to date and sign the form and return it to:

United Administrative Services
Attn: Lynda M. Rodarte
Administration Department
6800 Santa Teresa Blvd. Ste. 100
San Jose, CA 95119

I (we) understand and agree that any pre-existing conditions (conditions for which medical advice or treatment has been received or recommended in the past six months) will not be covered until six consecutive months after the effective date of coverage. I (we) understand that if I (we) plan on replacing any existing group medical coverage with this plan, then this pre-existing condition limitation will be waived to the extent it

was satisfied under the previous policy. I (we) understand that coverage will become effective on the first day of the month following receipt by the Company of this enrollment form and first premium payment.

Date: _____ Retiree Signature: _____

Date: _____ Spouse Signature: _____
(if enrolling)

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