Group Retiree Health Insurance Plan Enrollment Form

THE HARTFORD

Hartford Life & Accident Insurance Company **Policy Numbers:**

Policyholder: **Delphi Salaried Retiree Association Benefit Trust**

(Please print clearly in ink or type)

Retiree's Name: _____
First Middle Last

Street: _____

City, State, Zip: _____ Social Security # : _____

Medicare ID#: _____

Gender: ☐ Male ☐ Female Date of Birth _____ Phone # : _____

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

Gender: ☐ Male ☐ Female Date of Birth _____: Social Security #: _____

Spouse Medicare ID# _____

Please check the medical plan you are enrolling:

	Choice	**Premium**	**Premium Plus**	**Elite**
Retiree	☐	☐	☐	☐
Spouse	☐	☐	☐	☐

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

Benistar Administrative Services, Inc. (BASI)
10 Tower Lane, First Floor
Avon, CT 06001
1-800-236-4782

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)