KTF DIABETES ENROLLMENT FORM

Diabetes Enrollment:	**KTF Compliance Office**
Mail Form:	**416 Creekstone Ridge, Woodstock, GA 30188**
Phone:	**(844) 583-3863**
Fax:	**(770) 874-1097**

Member Name: _____ Member #: _____

Patient Name: _____ Type of Diabetes: _____

Patient Address: _____

Phone: _____ E-mail: _____

Patient Date of Birth: _____ Date Diabetes was Diagnosed: _____

Does patient have other health coverage? Check all that apply: [ ] Medicare [ ] Retiree [ ] Active Employee

Other coverage is with (insurer/employer): _____

Note: If Medicare or other employer coverage is primary, Rx must first be obtained from the primary plan and the member must then file for secondary coverage under the coordination of benefits rules with KTF. KTF will cover that portion of any drug not covered by the plan up to the maximum amount that would have been paid under the KTF Plan. The minimum Rx copay for coordination of benefits will be disregarded for enrolled diabetics.

Primary member is [ ] Retired from Kingston City Schools or [ ] Actively Employed.

Primary Physician (for diabetic care): _____

Physician Address: _____

Phone: _____ Fax: _____

Are you currently on insulin? [ ] Yes or [ ] No Dosage: _____

How long have you been on insulin? _____

How often do you test your Glucose Level? _____

Medical Release: I hereby authorize any health care facility, physician, surgeon, counselor, therapist, or insurance company to provide all information pertaining to me (or any of my dependents or spouse who are covered) regarding past or present medical or mental conditions, any examination or treatment, including treatment for alcohol abuse, substance abuse, mental or emotional disorders, AIDS, ARC (Aids Related Complex), HIV and to any illness, injury or condition that I/We or my dependent(s) have had at any time (in the past or in the future) until the expiration of this authorization and/or coverage, to the following authorized personnel of the individuals and companies responsible for the administration of this plan: KTF, the Claims Supervisor, any third parties contracted to provide service for this plan (pre-certification firm, PPO, case manager, agent, or prescription benefit manager, etc.), and my employer only for purposes of eligibility, payment of claims, verification of benefits and any treatment. No information will be used for any employment related matter. I understand this information is collected in connection with the evaluation and processing of any eligibility for benefits, determining medical necessity and treatment, under this Plan. This authorization is valid as long as I am covered by this Plan or until changed in writing; and a photocopy is as valid as the original. I understand that this information shall be treated with utmost confidentiality and will be separately maintained from my employment information accordingly to the Plan's Privacy Policy.

Patient: _____ Date: _____

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DIABETES PLAN DISCLOSURE
(For Retention by the Member/Patient)

Special benefits are provided to those members enrolled in this program, subject to verification they have a diabetic or potential diabetic condition. At the option of the Plan, you may be placed in a disease state management program. This is a special case management program with specialists who will track, monitor, and coordinate your treatment program with you and your providers. Prior to enrollment, benefits for diabetes prescriptions and supplies will be paid as provided under the basic plan and not this special program.

- You will be given a toll-free number to contact for questions and information.
- This is a very important program that will assist you in maintaining your health and "quality of life" while dealing with a deadly, serious disease. You, to a very great extent, control your own destiny.
- **Self-management is essential!** You must follow your diet, get proper exercise, take your medications, and monitor your glucose levels, as directed. Medicine alone cannot make you well or maintain your quality of life!
- **Diabetic supplies will be available from Manifest Pharmacy, and they will be delivered to your door every 90 days. Call (888) 770-4009 to sign up for direct delivery of your test strips, monitor, etc.**

Note: If Medicare or other employer coverage is primary, Rx must first be obtained from the primary plan and the member must then file for secondary coverage under the coordination of benefits rules with KTF in order to be reimbursed your copay or coinsurance under the primary Rx plan. You will be required to pay your normal copay or coinsurance under the primary plan and submit the prescription drug receipt which shows the portion paid by insurance and the portion you paid for the prescription. KTF will cover that portion of the drug cost not covered by the plan up to the maximum amount that would have been paid under the KTF Plan. Prescription drug benefits are paid as a major medical benefit when the KTF plan is secondary.

When Medicare is your primary plan *(when both you and your spouse, if married, are retired, and not actively employed)* **diabetic supplies are covered under Medicare Part B. You must first purchase your diabetic supplies with your Medicare ID card, and you will have to pay your portion (usually 20%) at the time you pick up or order your prescription drugs and then submit the receipt for reimbursement to KTF as the secondary plan.**

It is the member's responsibility to know which plan is primary and which plan is secondary and to inform the druggist accordingly. You should only provide your drug store with a copy of your primary drug coverage.

Members are responsible for updating the plan any time there is a change in health or prescription coverage; and change in family status or eligibility for coverage; or any change in employment or retirement status. Members must submit a new enrollment form advising the plan of the changes. Forms are available online at www.ktftrustfund.com.

Should you have any specific questions about the diabetic program, you may contact the KTF Compliance Office at 844-583-3863 x1.