YEAR 2018 MEDICARE PLAN ELECTION FORM
FOR RETIREES OF ELECTRIC BOAT CORPORATION

As an Electric Boat retiree, spouse or surviving spouse, I understand the following:

1. Retirees, spouses or surviving spouses are eligible to voluntarily participate in the Electric Boat Retiree Medical and Prescription Drug Plan. All plan options are available to all eligible members regardless of state of residency.

2. Retiree and spouses are initially eligible on their Medicare effective date. In most cases, this is the first of the month of their 65th birthday. Retirees or spouses still working at age 65 or covered under a working spouse at the time they reach 65 can defer their initial eligibility to the first of the month following the date of retirement or loss of employer group coverage. Retirees and spouses eligible for Medicare due to disability can enroll in the plan.

3. **Retirees or spouses waiving the Unlimited prescription drug plan during their initial eligibility will NOT be given another opportunity to join.** In addition, retirees or spouses enrolling in the Unlimited Prescription Drug Plan who request termination of that coverage or opt down to the Limited Prescription Drug Plan will NOT be able to rejoin the Unlimited Prescription Drug Plan at a future date.

4. Retirees, spouses, and surviving spouses that do not qualify for an initial enrollment period or a special enrollment period, as outlined in #2 above, can enroll during the Electric Boat Open Enrollment Period which runs from November 15th through December 31st for an effective date of January 1st. New enrollees enrolling outside of these qualifying events can enroll in any of the EB Retiree Medical and Prescription Drug Plan options with the exception of the EB Retiree Unlimited Prescription Drug Plan.

5. Premiums are guaranteed until December 31st 2018. In participating in the program, the retiree or spouse is fully responsible and liable for any premiums associated with participating in the plan. Premiums will not be the responsibility of Electric Boat or Beacon Retiree Benefits Group.

6. In order to be eligible for these programs, the appropriate premium will be pension deducted on a monthly basis. If there is not a pension or the pension check is not large enough to cover the cost, you can choose to be billed monthly or you can enroll in our ACH program and we will automatically withdraw your premiums from your bank account on the 10th of each month.

7. Please note if you choose the Met Life Dental Option, you will enroll directly through MetLife and MetLife will bill you directly. There is only **one** opportunity to enroll in the MetLife Dental Plan.

8. Coverage can be terminated by notifying Beacon Retiree Benefits Group **in writing 30 days in advance** of desired termination date. Your pension or billing account will be adjusted appropriately.

Your effective date of coverage: _____

Personal Applicant Information – As it appears on your Medicare card			
If both retiree and spouse are enrolling, each applicant will need their own form			
Last Name	**First Name**	**MI**	**Date of Birth (mm/dd/yyyy)**
Gender ☐ **Male** ☐ **Female**	**Marital Status** ☐ **Single** ☐ **Married** ☐ **Widowed** ☐ **Divorced**		**Social Security #**
Medicare Number	**Medicare Part A Effective Date**		**Medicare Part B Effective Date**

Are you the Electric Boat Retiree? ☐ **Yes** ☐ **No**

If the answer is no, what is your relationship to the retiree? ☐ **Spouse** ☐ **Surviving Spouse**

Name of Electric Boat Retiree _____

Retiree Social Security # _____ Retiree Date of Birth _____

Are you currently employed? ☐ **Yes** ☐ **No**

If "no", please provide your retirement date _____

If "yes", are you working full-time or part-time _____

Mailing Address	**City**	
	State	**Zip Code**
Legal Street Address (if different than above)	**City**	
	State	**Zip Code**

Home Telephone ( )	**Alternative Phone (Cell)** ( )	**County**

Email Address

Do we have your permission to email you? ☐ **Yes** ☐ **No**

Are you a resident in an institution (skilled nursing facility, rehab hospital)? ☐ **Yes** ☐ **No**

If Yes, name of institution _____

Address of institution _____

City_____State_____Zip Code_____

Phone number of institution _____Date of Admission_____

Medical Information

Do you have End-Stage Renal Disease (ESRD)? ☐ **Yes** ☐ **No**
If "yes", how long have you been on Medicare for ESRD? Start Date _____

End Date _____

Some individuals may have other drug coverage, including other private insurance, Worker's Compensation, TRICARE, Federal employee health benefits coverage, VA benefits, or State Pharmaceutical Assistance Programs.
Will you have other prescription drug coverage in addition to this plan? ☐ Yes ☐ No

If "yes", please list other coverage and identification numbers for this coverage:

Name of other coverage _____

Your member ID# for this coverage _____Group # _____

Will you have any health insurance other than Medicare, such as private insurance, Worker's Compensation, VA benefits or other employer coverage? ☐ Yes ☐ No

If "yes", what is the name of the health insurance? _____

Your member ID# for this coverage _____Group #_____

Your 2018 Electric Boat Plan Election - check one of the following:

The Hartford Group Retiree Insurance Plans (Medical Only)		
	The Hartford Group Retiree Insurance Plan **High** Option	**$233.60**
	The Hartford Group Retiree Insurance Plan **Base** Option	**$172.00**
	The Hartford Group Retiree Insurance Plan **Low** Option	**$142.00**
The Hartford Group Retiree Insurance Plan & Express Scripts Medicare (PDP) Prescription Plan Options:		
	The Hartford Group Retiree Insurance Plan **High** Option with **Limited** Drug Plan	**$322.99**
	The Hartford Group Retiree Insurance Plan **High** Option with **Unlimited** Drug Plan	**$398.88**
	The Hartford Group Retiree Insurance Plan **Base** Option with **Limited** Drug Plan	**$261.39**
	The Hartford Group Retiree Insurance Plan **Base** Option with **Unlimited** Drug Plan	**$337.28**
	The Hartford Group Retiree Insurance Plan **Low** Option with **Limited** Drug Plan	**$231.39**
	The Hartford Group Retiree Insurance Plan **Low** Option with **Unlimited** Drug Plan	**$307.28**
The Hartford Group Retiree Insurance Plan monthly costs are guaranteed through December 31, 2019. Express Scripts Medicare Prescription Drug Plan monthly costs are guaranteed through December 31, 2018.		

☐ **I would like my insurance premiums pension deducted.**

☐ **I would prefer to be billed monthly & have my bill emailed to me.**

☐ **I would prefer to be billed monthly & have my bill sent to me via US Mail.**

☐ **I would like Direct Payment (ACH Debit) and will complete the ACH form.**

ATTENTION! Please sign and date

By signing below, I agree that I have read and understand the contents of this Plan Election Form and the benefits described in the 2018 Electric Boat Benefits Guide. I agree that the information provided by me is accurate and complete.

This Plan Election Form must be signed, dated and received prior to your desired effective date. Upon receipt, your form will be processed and your enrollment will be sent to The Hartford and Express Scripts Medicare. The plan will submit your enrollment to CMS in accordance with CMS (Centers for Medicare and Medicaid) guidelines.

_____ _____

Applicant Signature (or signature of authorized representative) **Date signed**

If you are the authorized representative of the applicant, you must provide the following information and sign below. If signed by an authorized representative of the applicant, 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 Beacon Retiree Benefits Group, The Hartford, Express Scripts Medicare or Medicare.

_____ _____

Name (Print) **Signature**

_____

Address

_____

Telephone Number **Relationship to Applicant**

If someone assisted you in completing this form, please have that person complete the information below:

_____ _____

Signature of Individual Who Assisted in Completing this Form **Relationship to Applicant**

Date: _____

This form should be returned to: Beacon Retiree Benefits Group LLC 710 Main Street, Suite #10, Plantsville, CT 06479

IMPORTANT INFORMATION: Electric Boat Corporation ("EB") does not endorse or sponsor this program and your participation in it is completely voluntary. As such, EB has no responsibility with respect to the program other than to help establish the "group" for state insurance law purposes and to forward your premiums through pension payment deductions. THIS PROGRAM WILL OPERATE FROM YEAR TO YEAR AND MAY BE MODIFIED OR TERMINATED BY THE INSURANCE COMPANY IN ACCORDANCE WITH THE POLICY GOVERNING THIS PROGRAM. ALSO, EB, IN ITS SOLE DISCRETION, MAY DECIDE TO END ITS ASSOCIATION WITH THE PROGRAM AT THE END OF ANY GIVEN YEAR. In no event shall EB be responsible or liable for the termination or continuation of this program or for any loss incurred in connection with this program. This program is not an employee benefit plan subject to the Employee Retirement Income Security Act of 1974.