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FOR DESERET MUTUAL USE ONLY	
RETIREMENT DATE OR EFFECTIVE DATE OF CHANGE	COMPANY CODE

## RETIREE BENEFIT PROGRAM ENROLLMENT FORM

### A. PERSONAL INFORMATION

Retiree name (last, first, initial): \_\_\_\_\_

Social Security number: \_\_\_\_\_

Deseret Mutual ID number: \_\_\_\_\_ Medicare number: \_\_\_\_\_

Sex:  Male  Female      Marital status: \_\_\_\_\_

Home address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP code: \_\_\_\_\_

Phone number: (\_\_\_\_\_) \_\_\_\_\_ Birth date (mm/dd/yyyy): \_\_\_\_\_

Mailing address (if different from above): \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP code: \_\_\_\_\_

### B. YOUR INSURANCE COVERAGE (REQUIRED)

**Select your level of insurance coverage:**

- For myself     For myself and one dependent\*     For myself and two or more dependents\*

\* Complete the back of the last page in this enrollment form

**If you or your dependents are eligible for Medicare, select your medical plan:**

- Deseret Secure     Deseret Secure *PLUS*

**If you or your dependents are *not* eligible for Medicare, select your medical plan:**

- Deseret Choice (available in Utah, Hawaii, and Southeastern Idaho)  
 Deseret Select (available in Utah and Southeastern Idaho)  
 Deseret Premier (available *outside* Utah, Hawaii, and Southeastern Idaho)  
 Deseret Value     HMO

If you select Deseret Choice and you live in Hawaii, name your primary care physician (PCP):  
 \_\_\_\_\_

If you select an HMO, attach the HMO application and provide the name of the HMO:  
 \_\_\_\_\_

**Check the box below if you want *only* life insurance coverage:**

- Group Term Life Insurance ***only*** (waiver of medical benefits). **I understand I may *not* apply for medical benefits later except under certain circumstances.**

## C. RETIREE AUTHORIZATION

By completing this enrollment application, I agree to the following:

### PREMIUM DEDUCTION

I hereby apply for the insurance benefits specified and authorize the deduction of my portion of the premiums from my Master Retirement Plan check. If my Master Retirement Plan check is not large enough to cover the premium, I'll be billed individually for this coverage and agree to pay the premium to Deseret Mutual. I understand the benefits of this program, including the various options and conditions given herein.

### ELIGIBILITY REQUIREMENTS

Because Deseret Secure is a Medicare Advantage Private Fee-for-Service plan, I must remain enrolled in Medicare Parts A and B. Also, I can only enroll in one Medicare Advantage plan at a time. It's my responsibility to inform Deseret Mutual of any prescription drug coverage I have or may get in the future. Enrollment in this plan is generally for the entire year. I may disenroll only at certain times of the year, or under certain special circumstances, by sending a request to Deseret Mutual.

### INFORMATION RELEASE

I authorize Deseret Mutual to release my information to Medicare and other plans as necessary for treatment, payment, and health-care operations. Furthermore, I authorize any physician, medical practitioner, hospital, clinic, any other health-care provider, or insurance company to disclose to Deseret Mutual or its representatives all information and records about any physical or mental condition or treatment of me, my spouse, or my dependents relating to diagnosis, treatment, medical history, and physical or mental condition.

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 Deseret Mutual 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: \_\_\_\_\_

Phone number: (\_\_\_\_\_) \_\_\_\_\_ Relationship to enrollee: \_\_\_\_\_

## D. MEDICARE INSURANCE INFORMATION

Fill in the blanks below so they match your red, white, and blue Medicare card. If you have more than one dependent on Medicare, please attach copies of the additional cards. Please be aware, you must be enrolled in Medicare Parts A and B to join our Medicare Advantage Private Fee-for-Service plan.

### Your Medicare Card Information

### Your Dependent's Medicare Card Information

MEDICARE  HEALTH INSURANCE	MEDICARE  HEALTH INSURANCE
<b>SAMPLE ONLY</b>	
Name: _____	Name: _____
Medicare Claim Number: _____ Sex: _____	Medicare Claim Number: _____ Sex: _____
Is Entitled to: _____ Effective Date: _____	Is Entitled to: _____ Effective Date: _____
HOSPITAL INSURANCE (PART A) _____	HOSPITAL INSURANCE (PART A) _____
MEDICAL INSURANCE (PART B) _____	MEDICAL INSURANCE (PART B) _____

## BENEFICIARY DESIGNATION

To name your primary and alternate beneficiaries for life insurance benefits, please complete the *Basic and Supplemental Life Insurance Beneficiary Designation* form.

## E. RETIREE WAIVER OF INSURANCE BENEFITS (Sign *only* if you reject all benefits)

I understand the benefits of this program include Medical and Group Term Life Insurance. 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.**

Printed name: \_\_\_\_\_

Retiree signature: \_\_\_\_\_ Date: \_\_\_\_\_

## F. OTHER MEDICAL INSURANCE

Are you covered by any medical plan other than a Deseret Mutual plan?  Yes  No

If yes, provide the following information:

Carrier name: \_\_\_\_\_

Carrier address: \_\_\_\_\_

Carrier telephone number: (\_\_\_\_\_) \_\_\_\_\_

Policy holder: \_\_\_\_\_

Policy number: \_\_\_\_\_

## G. DESERET MUTUAL USE ONLY

Employment Status	Underwriting Status	Benefit Package	Contract Type	Risk Population	Premium Split Code	Bill to Code	Comments: _____	Date: _____
							_____	_____
							Monthly Medical Premium: _____	_____

