DMBA

Senior Service Medical Plan (provided by contract with)
Deseret Mutual Benefit Administrators
P.O. Box 45730 • Salt Lake City, UT 84145
Telephone: 801-578-5650 • Toll free: 800-777-1647
Email: srmiss@dmba.com • Fax: 801-578-5907
Website: www.dmba.com/ssmp

SENIOR SERVICE MEDICAL PLAN ENROLLMENT FORM

DMBA ID 00 __ __ __ __ __ __ __	**FOR DMBA USE ONLY**		Sub Add ___	
Group X __ __ __ __ __ Bp __ __	Contract ___	EFT ___	Pre ___	
ES = A and/or PM; Bc = II or CC	Corp ___	Rmk ___	Miss ___	
Miss # ___ ___ ___ ___ ___ ___	PM ___	Mbr Add ___	PM ___	Welcome Ltr ___

MONTHLY PREMIUM: $275.04 per person per month

To enroll in the Senior Service Medical Plan (SSMP), please complete this form in full on both sides, sign it, and return it to DMBA. **Your effective date may begin either: 1) the first day of the month one month before your service begins if you are serving outside the U.S. and want time to obtain a 12-month supply of medications to take with you; or 2) the first day of the month your service begins when you enter the MTC or begin missionary service.** Premiums are collected by monthly electronic funds transfer (EFT) from a U.S. checking or savings account. If you can't pay premiums by EFT, please contact DMBA for other options. Premiums are collected on or around the 5th of each month.

VOLUNTEER INFORMATION

If you are married and your spouse needs the SSMP, please complete an additional form.

Volunteer status: ❑ Single ❑ Married Gender: ❑ Male ❑ Female

Volunteer name (first, middle initial, last): _____

Social Security number:_____ Birth date (MM/DD/YYYY):_____

ASSIGNMENT INFORMATION

Assignment Sponsor:

❑ Temple ❑ CES ❑ Welfare

❑ Missionary ❑ BYU ❑ Family History

❑ Other (please specify): _____

Mission or entity name: _____

Assignment location: _____

Requested coverage effective date: _____ MM/DD/YYYY

Assignment end date: _____ MM/DD/YYYY

MAILING, EMAIL ADDRESS, & TELEPHONE INFORMATION

You will receive communication before, during, and after your service. Please provide us with the following information:

Before Mission (Current Mailing) Address, Phone Number, Email	**During Mission** (Mission, Temple, Area Office, etc.) Address, Phone Number, Email	**After Mission** (Permanent Home) Address, Phone Number, Email
Address	Address	Address
City State Zip	City State Zip	City State Zip
Country Phone	Country Phone	Country Phone
Email	Email	Email

PLEASE COMPLETE BOTH SIDES OF THIS FORM **SS01B2MMN1018**

CONTACT PERSON INFORMATION

Sometimes we may have trouble reaching you during your service. To help us keep in contact, please list a trustworthy person we can communicate with to review issues about your plan.

Name: _____ Phone: _____

Address: _____ Email: _____

City: _____ State: _____ ZIP code: _____Country:_____

POST-MISSION TRANSITIONAL COVERAGE INFORMATION

If you will ***NOT*** be eligible for any other coverage (Medicare, governmental, retiree, employer, individual, etc.) when you return home from your assignment, you may choose to remain enrolled in the plan for up to 60 days after you return home. You should find out now what insurance options you will have when you return home. To be eligible for Post-mission Transitional Coverage, you must indicate that you want it on this enrollment form. **You will not be able to choose this coverage after your service begins**.

Please mark the appropriate box and initial in the area provided to show your election for Post-mission Transitional Coverage:

❑ No ❑ Yes (Please Initial _____)

TERMS & CONDITIONS

By enrolling in the Senior Service Medical Plan (SSMP), I acknowledge and agree to the following conditions:

- I authorize any physician, medical practitioner, hospital, clinic, other healthcare provider, or insurance company to disclose to DMBA, Aetna International, or their representatives, all information and records with respect to any claim, physical or mental condition, treatment, medical history, and/or evaluation thereof.
- I understand benefits are different when services are incurred outside the United States versus inside the United States. This includes but is not limited to medical deductible, coinsurance, and out-of-pocket maximum amounts.
- If I serve outside the United States and I am not already covered, I agree to get coverage as soon as I can before returning home from my mission, whether it be retirement, employer-sponsored, individual policy, governmental (such as Medicare Parts A and B), or other coverage that may provide benefits when I return home. I understand the SSMP is not intended to provide long-term coverage and will end the last day of the month I complete missionary or volunteer service and am no longer required to follow the missionary or volunteer schedule.
- If I serve inside the United States, I agree to continue existing coverage or get coverage when I become eligible while serving, whether it be retirement, employer-sponsored, individual policy, governmental (such as Medicare Parts A and B), or other coverage that may provide benefits during my mission and when I return home. This will ensure I am covered upon my return home because the SSMP is not intended to provide long-term coverage. I understand that my out-of-pocket expenses (deductible, copayments, coinsurance, etc.) in the United States will be more if I go to an out-of-network provider.
- I recognize if I discontinue my coverage with SSMP and do not have other adequate coverage, DMBA will notify the Missionary Department or my sponsoring organization and I may be asked to change my assignment or return home because of insufficient coverage.
- If I choose Post-mission Transitional Coverage, I am covered for the 60 days allowed by the plan, unless I get other insurance coverage. Otherwise, I agree to continue the coverage for the full 60 days whether I use it or not. I am required to pay the appropriate premiums for the coverage. I also acknowledge I have no other governmental or employer-sponsored coverage to provide benefits upon my return home.
- I understand to maintain the financial integrity of the SSMP, Aetna International has the right to change the premium or benefits annually.My signature below acknowledges I have read and agree to the terms and conditions outlined above.

Signature: _____ Date:_____

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SENIOR SERVICE MEDICAL PLAN
AUTOMATIC CREDIT CARD PAYMENT AUTHORIZATION

Please note: Because of security requirements and for your protection, please do not fax or email this form to DMBA. Instead, mail it to the address above or call us.

If you can't pay Senior Service Medical Plan (SSMP) fees by electronic fund transfers (EFTs), you may pay by credit card. Fees will be charged to your account on or around the 5th of each month. Credit card payment is intended for those who reside outside of the United States. If you can't pay by credit card or EFT, contact DMBA to discuss other alternatives.

I/We hereby authorize DMBA, upon enrollment in the SSMP, to initiate debits for the monthly fee amount to the credit card institution and account indicated below. This authorization will remain in effect until cancelled by me/us or the credit card institution identified with the account. As protection, I/we will be notified of future fee changes at least 30 days in advance. I/we understand that by revoking **automatic credit card payment** of fees, coverage with the SSMP will end. This authorization is automatically revoked upon cancelation of coverage. The signature(s) below validate this authorization, require information on this authorization to be held confidential by DMBA, and indicate a desire to enroll in the SSMP.

Credit card institution: _____

Credit card number: _____

Expiration date: _____ Card type: ❑ Visa ❑ American Express ❑ Discover ❑ MasterCard

Your billing address: _____

City: _____ Province: _____

Postal code: _____ Country: _____

Account holder signature: _____ Date: _____

Joint account holder signature: _____ Date: _____