

Medicare Supplement Enrollment Application

PERSONAL INFORMATION				
Social Security Number		Name of employee (<i>last, first, middle initial</i>)		
Address (<i>number and street</i>)		City/State/ZIP		
Telephone number (<i>with area code</i>) () -		E-mail address @		
Relationship Status: <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Married <input type="checkbox"/> Civil Union <input type="checkbox"/> Divorced <input type="checkbox"/> Domestic Partnership		Title: <input type="checkbox"/> Ms. <input type="checkbox"/> Mr. <input type="checkbox"/> Rev. <input type="checkbox"/> Dr.	Do you or any member of your family have other medical coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, list carrier name and address:	
PROVIDE EMPLOYEE AND DEPENDENT(S) INFORMATION BELOW (Use additional sheet if necessary)				
Name (last, first, middle initial)	Relationship to participant	Date of birth (mm/dd/yr)	Social Security Number	Gender
	Self		XXX-XX-XXXX	
	Spouse/Partner			
Employee: Please read and sign below. (<i>Unsigned applications will be returned.</i>) I certify that the adult child(ren) listed above is (are) not eligible to enroll in an eligible employer-sponsored health plan. If my status or my dependent's status changes, I agree to notify the Pension Boards immediately. I hereby enroll in the UCC Medical Benefits Supplement Health Plan.				
Are you enrolled in Medicare Part A: <input type="checkbox"/> Yes <input type="checkbox"/> No Medicare Part B: <input type="checkbox"/> Yes <input type="checkbox"/> No				
SIGNATURE				
Employee signature			Date	
EMPLOYER INFORMATION (if applicable, see reverse)				
Name of employer		Date of hire	Hours worked per week	
Address (number and street)		City/State/ZIP		
Employer Signature			Date signed	

Please return to the Pension Boards at the address indicated above, and retain a copy for your records.

INSTRUCTIONS

Please complete all required information and sign your enrollment application. Any incomplete, unsigned application will be returned and not accepted by the Pension Boards.

Eligible employees must enroll in the UCC Medicare Supplement Health Plan within 90 days of initial UCC employment.

“**Employee**” means the primary subscriber who is enrolled in and covered by the UCC Medicare Supplement Health Plan.

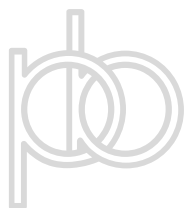
“**Dependent(s)**” includes the spouse or domestic partner and children.

Employer Signature is required if UCC Medicare Supplement Health Plan contribution rates are paid by the employer.

Please be sure to list all dependents to be covered under your policy with the UCC Medicare Supplement Health Plan. Use an additional sheet of paper if necessary.

QUESTIONS? NEED ASSISTANCE?

The Pension Boards staff is available to assist you in this important process. Please feel free to contact a Member Services Representative toll-free at **1.800.642.6543, Option 6**, or by e-mail at **info@pbucc.org**.



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