**Return your completed form to:**
Kentucky Retirement Systems
1260 Louisville Rd. • Frankfort KY 40601-6124
Phone: (502) 696-8800 • Fax: (502) 696-8822 • kyret.ky.gov

**Form 6200**
**Plan Year 2021**
Revised 09/2020

## Kentucky Retirement Systems Health Plans for Medicare Eligible Persons

*Kentucky Retirement Systems Health Plans offer medical and prescription drug coverage.*
To enroll in a Kentucky Retirement Systems Health Plan, please provide the following information.

| **Enrollee Information: The enrollee is the person applying for coverage.** | | |
|---|---|---|
| Enrollee Name: | | Enrollee SSN: |
| Retiree Name: | | Member ID: |
| Enrollee DOB: | Email: | Phone Number: |
| Permanent Residence Street Address (P.O. Box not allowed): | | |
| City: | State: | Zip Code: |
| Mailing Address (only if different from permanent residence): | | |
| City: | State: | Zip Code: |

If you are not the retiree, what is your relationship to the retiree?

☐ Spouse ☐ Dependent Child ☐ Other (please explain)

A copy of your Medicare Card or Social Security Awards Letter is required to enroll. If a copy of your Medicare Card (Red, White, and Blue) is not already on file, please send a copy with this Enrollment Form.

**Please read and answer these important questions.**

Do you have End-Stage Renal Disease (ESRD)? ☐Yes ☐No
If you have had a successful kidney transplant and/or you do not need regular dialysis any more, **please attach a note or records** from your doctor showing you have had a successful kidney transplant or you don't need dialysis, otherwise we may need to contact you to obtain additional information.

**Employment After Retirement**

If you are Medicare eligible and return to work, KRS may not be able to offer you coverage due to the MSP (Medicare Secondary Payer) requirement. You may have to utilize your employers group health plan. Please call KRS if you have questions. You should also contact Medicare if you have questions.

| | |
|---|---|
| Is the Enrollee employed? ☐ Yes ☐ No | If yes, is the Enrollee Self-Employed? ☐ Yes ☐ No |
| Employer Name (without abbreviations): | |
| Employer Street Address: | |
| Is the Enrollee eligible for Employer's Group Health Plan? ☐ Yes ☐ No | |
| Is the Enrollee enrolled in the Employer's Group Health Plan? ☐ Yes ☐ No | |
| Is the Enrollee in the process of retiring? ☐ Yes ☐ No | If yes, what is their retirement date? |

**Paying your plan premium.**

**If you are assessed a Part D-Income Related Monthly Adjustment Amount, you will be notified by the Social Security Administration. You will be responsible for paying this extra amount in addition to your plan premium. You will either have the amount withheld from your Social Security benefit check or be billed directly by Medicare or Railroad Retirement Board (RRB). DO NOT pay Kentucky Retirement Systems the Part D- IRMAA.**

**If you are an authorized representative, please read the important notice below.**

If you are an authorized representative completing this form on behalf of the applicant, you must provide our office with documentation of your legal authority to act on their behalf. Documentation of legal authority to act may consist of one of the following: a completed KRS Form 6460 "Special Power of Attorney"; a valid guardianship or emergency guardianship order; a valid Power of Attorney containing provisions allowing for health care decisions; a valid Living Will with a designation of a health care surrogate(s); or other documentation as approved by the Kentucky Retirement Systems. You can find KRS Form 6460 on our website at https://kyret.ky.gov or contact our office at (800) 928-4646 to request a copy.

This Enrollment Form will not be valid until the appropriate documentation is filed with our office and approved by the Kentucky Retirement Systems' legal department.

**By completing this Enrollment Form, I agree to the following:**
I will need to keep my Medicare Part A and/or Part B coverage. Enrollment in this plan is generally for the entire year. Once I enroll, I may leave this plan or make changes if an enrollment period is available, generally during the Annual Enrollment Period unless I qualify for certain special circumstances.

**Release of Information:**
By joining this Medicare prescription drug plan, I acknowledge that Humana Group Medicare Advantage PPO will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that Humana Group Medicare Advantage PPO will release my information, including my prescription drug event data, to Medicare, who may release it for research and other purposes which follow all applicable Federal statutes and regulations. I authorize release of all Medicare Part A, Part B and Part D (Part C) claims information from any source for the purpose of processing my claims. This authorizes release of my Medicare claims information from the effective date of my coverage until termination of my coverage. The information on this Enrollment Form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.

Any person who knowingly and with intent to defraud any insurance company or other person files an Enrollment Form for insurance containing any materially false information or, for the purpose of misleading, conceals information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

I understand that my signature (or the signature of the person authorized to act on my behalf under State law where I live) on this Enrollment Form means that I have read and understand the contents of this Enrollment Form. 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 Humana Group Medicare Advantage PPO, Kentucky Retirement Systems Health Plan or by Medicare.

## Waiver of Coverage/Disenrollment of Coverage

**PLEASE BE ADVISED THAT IF YOU DO NOT WAIVE COVERAGE OR DISENROLL FROM COVERAGE, YOU WILL AUTOMATICALLY BE ENROLLED INTO A PLAN FOR THE 2021 PLAN YEAR**

If you currently have coverage and wish to disenroll, please check the box below.

| | |
|---|---|
| ☐ I wish to waive coverage or disenroll* | Reason: |

* If you waive coverage or disenroll, you will not be allowed to change this election until the next open enrollment period unless you experience a qualifying event. If you wish to waive coverage or disenroll, complete all requested information on this form, then provide the necessary signatures on the last page of this form.

## Available Plans

Please check which plan you want to enroll in.

- ☐ Kentucky Retirement Systems Medical Only** (The Medical Only Plan does not have prescription drug coverage).
- ☐ Humana Group Medicare Advantage PPO Plan - KRS Essential Prescription Drug Plan
- ☐ Humana Group Medicare Advantage PPO Plan - KRS Premium Prescription Drug Plan

** If you enroll for coverage under Medicare Part D, the only KRS plan that you may elect is the Health Plan – Medical Only.

## Certification

Applicant's Signature: _____ Date: _____

Retiree's Signature
(if different from applicant): _____ Date: _____

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