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

**Form 6200**
**Plan Year 2015**
Revised 09/2014

## Kentucky Retirement Systems Health Plans for Medicare Eligible Persons

Print Form

*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.

### Applicant Information

If you know your KRS Member ID, please provide your Member ID in the box below.

| | | |
|---|---|---|
| Applicant Name: | | Member ID: |
| **IF YOU ENTER A P.O. BOX BELOW YOUR APPLICATION WILL NOT BE ACCEPTED AND YOU WILL NOT HAVE INSURANCE.** | | |
| 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: |
| Date of Birth: | Home Phone: | |
| E-mail Address: | Gender: ☐ Male | ☐ Female |

If you are not the retiree, what is your relationship to the retiree?
☐ Spouse ☐ Dependent Child ☐ Other (please explain) _____

### 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 2015 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**
☐ HUMANA MEDICARE EMPLOYER PPO - KRS ESSENTIAL PRESCRIPTION DRUG PLAN
☐ HUMANA MEDICARE EMPLOYER PPO - 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.

**Please provide your Medicare insurance information.**
**Important: Please submit a copy of the applicant's Medicare card if the applicant is a new enrollee.**

Please take out your Medicare card to complete this section.

- Please fill in these blanks so they match your red, white and blue Medicare card

-OR-

- Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.

You must have Medicare Part A or Part B (or both) to join our Medicare prescription drug plan.

MEDICARE HEALTH INSURANCE

SAMPLE ONLY

Name: _____

Medicare Claim Number Sex: _____

___ ___ ___ - ___ ___ - ___ ___ ___ ___ ___

Is Entitled To Effective Date

HOSPITAL (Part A) _____

MEDICAL (Part B) _____

**Paying your plan premium.**

If your monthly benefit is not large enough to pay your portion of your monthly insurance premium, you will be responsible for paying the balance. For your convenience, you may have this payment automatically deducted from your bank account. To set up an automatic deduction, please complete and return Form 6131, Bank Draft Authorization for Direct Pay Accounts, to our office. You may also prepay your monthly payment up to six months in advance for the months of January through June and July through December. This means beginning in January you may prepay through June. If you do not have your payment automatically deducted, you will receive a bill each month.

**If you are assessed a Part D-Income Related Monthly Adjustment Amount (IRMAA), 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 be billed directly by Medicare. Do NOT pay the Kentucky Retirement Systems Health Plan the Part D-IRMAA extra amount.**

**Please answer the following questions.**

1. Some individuals may have other drug coverage, including other private insurance, TRICARE, Federal employee health benefits coverage, VA benefits, or State pharmaceutical assistance programs.

Will you have other prescription drug coverage in addition to Kentucky Retirement Systems Health Plans? ☐ Yes ☐ No

2. If you answered yes to Question 1, please list your other coverage and your identification (ID) number(s) for this coverage. Please provide a copy of your prescription drug card with this form.

Name of other coverage: _____

ID # for this coverage: _____

Group # for this coverage: _____

Effective date for this coverage: _____

BIN # for this coverage: _____

PCN # for this coverage: _____

Termination date for this coverage: _____

3. How do you qualify for Medicare? ☐ Age 65 ☐ Disability ☐ End Stage Renal Disease

4. If you qualify for Medicare due to End Stage Renal Disease, please provide the date of diagnosis:

## Please read and sign below:

**By completing this enrollment application, 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 (October 23 - November 29), unless I qualify for certain special circumstances.

**Release of Information:**
By joining this Medicare prescription drug plan, I acknowledge that Humana Employer 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 Employer 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 application means that 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 Humana Employer PPO, Kentucky Retirement Systems Health Plan or by Medicare.

## 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.

## Certification

Applicant's Signature: _____ Date: _____

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

## Return your completed application to:

**Kentucky Retirement Systems, Perimeter Park West, 1260 Louisville Road, Frankfort, KY 40601-6124**