YEAR 2024 MEDICARE PLAN ELECTION FORM

Your effective date of coverage			
Personal Applicant Information – As it appears on your Medicare card			
If both retiree and spouse are enrolling, each applicant will need their own form			
Last Name	**First Name**	**MI**	**Date of Birth (mm/dd/yyyy)**
Gender ☐ **Male** ☐ **Female**	**Marital Status** ☐ **Married** ☐ **Single** ☐ **Widowed** ☐ **Divorced**		**Social Security #**
Medicare Claim #	**Medicare Part A Effective Date**	**Medicare Part B Effective Date**	
Are you the Electric Boat Retiree? ☐ **Yes** ☐ **No** **If the answer is no, what is your relationship to the retiree?** ☐ **Spouse** ☐ **Surviving Spouse**			
Name of Electric Boat Retiree			
Retiree Social Security#		**Retiree Date of Birth**	
Are you currently employed? ☐ **Yes** ☐ **No**			
If "no", please provide your retirement date			
If "yes", are you working full-time or part-time			
Mailing Address	**City**		
	State	**Zip Code**	
Legal Street Address (if different than above)	**City**		
	State	**Zip Code**	
Home Telephone	**Alternative Phone (Cell)**	**County**	
Email Address			
Do we have your permission to email you? ☐ **Yes** ☐ **No**			

Premium Payment Options – please indicate how you would like to pay your premium below:

- ☑ **Please deduct from my GD pension check or the GD pension check of my spouse.**
- ☐ **Please email a monthly statement.**
- ☐ **Please send a monthly statement to me via US Mail.**
- ☐ **Please deduct monthly payments from my designated bank account. My ACH form is attached. I understand that automatic (ACH) deductions are taken on the 10th of the month.**

If you are a new retiree and we are unable to deduct from your first pension check, we will bill you for the 1st month and begin deductions the following month.

Your 2024 Medicare Plan Election - check one of the following options:

EB Medical Only Plans ONLY (No Rx)		
☐	United American Group Retiree **Plan G**	**$216.50**
☐	Anthem **High** Option Medicare Preferred PPO *****	**$152.76**
☐	Anthem **Base** Option Medicare Preferred PPO *****	**$108.37**
☐	Anthem **Low** Option Medicare Preferred PPO *****	**$82.39**

***Anthem Medicare Preferred PPO members cannot enroll in their own individual Medicare Part D plan and will need to enroll in one of the Medicare Part D prescription drug plans offered through this program in order to obtain drug coverage.**

United American Group Retiree Plan G members can have their own individual Medicare Part D plan.

EB Retiree Medical Plan and Medicare Part D Prescription Drug Plan Combinations:		
☐	United American Group Retiree **Plan G** & Express Scripts **VALUE** Rx	**$305.50**
☐	United American Group Retiree **Plan G** & Express Scripts **LIMITED** Rx	**$343.50**
☐	United American Group Retiree **Plan G** & Express Scripts **UNLIMITED** Rx	**$421.50**
☐	Anthem **HIGH** Option Medicare Preferred PPO & Express Scripts **VALUE** Rx	**$241.76**
☐	Anthem **HIGH** Option Medicare Preferred PPO & Express Scripts **LIMITED** Rx	**$279.76**
☐	Anthem **HIGH** Option Medicare Preferred PPO & Express Scripts **UNLIMITED** Rx	**$357.76**
☐	Anthem **BASE** Option Medicare Preferred PPO & Express Scripts **VALUE** Rx	**$197.37**
☐	Anthem **BASE** Option Medicare Preferred PPO & Express Scripts **LIMITED** Rx	**$235.37**
☐	Anthem **BASE** Option Medicare Preferred PPO & Express Scripts **UNLIMITED** Rx	**$313.37**
☐	Anthem **LOW** Option Medicare Preferred PPO & Express Scripts **VALUE** Rx	**$171.39**
☐	Anthem **LOW** Option Medicare Preferred PPO & Express Scripts **LIMITED** Rx	**$209.39**
☐	Anthem **LOW** Option Medicare Preferred PPO & Express Scripts **UNLIMITED** Rx	**$287.39**

Electric Boat Retiree Medical and Medicare Part D Prescription Drug Plan monthly premiums are guaranteed through December 31, 2024.

OPTIONAL INFORMATION

Answering these questions is your choice. You can't be denied coverage because you don't fill them out.

Are you Hispanic, Latino/a, or Spanish origin? Select all that apply.

- ☐ No, not of Hispanic, Latino/a, or Spanish origin
- ☐ Yes, Mexican, Mexican American, Chicano/a
- ☐ Yes, Puerto Rican
- ☐ Yes, Cuban
- ☐ Yes, another Hispanic, Latino/a, or Spanish origin
- ☐ **I choose not to answer**

What is your race? Select all that apply.

- ☐ American Indian or Alaska
- ☐ Native Asian Indian
- ☐ Black or African
- ☐ American Chinese
- ☐ Filipino
- ☐ Guamanian or Chamorro
- ☐ Japanese
- ☐ Korean
- ☐ Native Hawaiian
- ☐ Other Asian
- ☐ Other Pacific Islander
- ☐ Samoan
- ☐ Vietnamese
- ☐ White
- ☐ **I choose not to answer**

Do you have an emergency contact or a friend or family member you would like to list as your emergency contact and authorize to contact Beacon on your behalf? ☐ **Yes** ☐ **No**

Name of emergency contact/authorized person

Best phone number for your emergency contact/authorized person

As an Electric Boat retiree, spouse or surviving spouse, I understand the following:

- **This is a voluntary plan available regardless of where I reside within the United States and U.S. Territories.**
- **My initial eligibility begins when I first become eligible & enrolled in both Medicare Part A and Part B. This can occur at age 65 if I am retired or if I am the spouse of a retiree. My initial eligibility may also occur at retirement if I retire at or after age 65 or if I am 65 or older when my spouse retires.**
- **If I waive prescription drug coverage during my initial eligibility, I will NOT be given another opportunity to enroll at a later date. The Unlimited prescription drug plan is only available during my initial eligibility.**
- **I can defer my initial eligibility if I am covered under another employer or covered as a dependent of my working spouse.**
- **If I choose to enroll in this program, I am fully responsible for my premiums associated with the plans I elect. Premiums are not the responsibility of Electric Boat or Beacon Retiree Benefits Group.**
- **If I would like to terminate my plan, I will need to notify Beacon Retiree Benefits Group in writing 30 days in advance of my desired termination date.**

ATTENTION! Please sign and date

By signing below, I agree that I have read and understand the contents of this Plan Election Form and the benefits described in the 2024 Electric Boat Benefits Guide. I agree that the information provided by me is accurate and complete. This Plan Election Form must be signed, dated and received prior to your desired effective date. Upon receipt, your form will be processed and your enrollment request will be sent to the insurance plan(s) as requested. The insurance plan(s) will submit your enrollment to CMS in accordance with CMS (Centers for Medicare and Medicaid) guidelines.

_____ _____

Applicant Signature (or signature of authorized representative) **Date signed**

If you are the authorized representative of the applicant, you must provide the following information and sign below. If signed by an authorized representative of the applicant, 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 Beacon Retiree Benefits Group, United American, Anthem Blue Cross and Blue Shield, Express Scripts Medicare or Medicare.

If you assisted the applicant in completing this form, please complete below:

Name (Print)	**Telephone**
Address	
Email	**Relationship to Applicant**
Signature	**Date**

This form should be returned to:	**Forms can also be faxed or emailed.**
Beacon Retiree Benefits Group LLC **710 Main Street, Suite #10** **Plantsville, CT 06479**	**Fax# 1.860.621.5074** **Email addresses can be found in your 2024 EB Benefits Guide in Section 1.**

IMPORTANT INFORMATION: Electric Boat Corporation ("EB") does not endorse or sponsor this program and your participation in it is completely voluntary. As such, EB has no responsibility with respect to the program other than to help establish the "group" for state insurance law purposes and to forward your premiums through pension payment deductions. THIS PROGRAM WILL OPERATE FROM YEAR TO YEAR AND MAY BE MODIFIED OR TERMINATED BY THE INSURANCE COMPANY IN ACCORDANCE WITH THE POLICY GOVERNING THIS PROGRAM. ALSO, EB, IN ITS SOLE DISCRETION, MAY DECIDE TO END ITS ASSOCIATION WITH THE PROGRAM AT THE END OF ANY GIVEN YEAR. In no event shall EB be responsible or liable for the termination or continuation of this program or for any loss incurred in connection with this program. This program is not an employee benefit plan subject to the Employee Retirement Income Security Act of 1974.