RCUH Form B-27 Checklist – Documents needed to process Retiree Group Health & Life Insurance Enrollment Application

- ☐ Before filling out this form, you will need to be an annuitant with TIAA as one of the eligibility requirements to be on the RCUH Retiree Group Health and Life Insurance Program per policy 3.550 Retiree Health and Life Insurance Program. Please provide proof that you are an annuitant with TIAA.
- ☐ If you have filled out Medicare information in section I, please ensure you are enrolled in Medicare Parts A and B. This is required if you are selecting a 65 years of age and over Health Insurance plan (HMSA Akamai Advantage or Kaiser Senior Advantage).
- ☐ If you selected a 2-party plan, please provide us with proof of legally recognized spouse or civil union partner such as marriage certificate or Civil Union License.
- ☐ If you have filled out Medicare information for your legally recognized spouse or civil union partner in Section III, please ensure your spouse or civil union partner is enrolled in Medicare Parts A and B.

If you have any questions, please call RCUH Benefits at 956-6979 or email at rcuh_benefits@rcuh.com,

Please turn to the next page to start filling out the form.

RCUH Research Corporation of the University of Hawai'i

RCUH is committed to protecting the security of your personal information.

Please submit via encrypted email to: rcuh_benefits@rcuh.com or FAX: 808-956-5022

Retiree Group Health & Life Insurance Enrollment Application

SECTION I: Employee/Retiree Information (please print or type)

Name: _____ **Date of Birth:** _____

Address: _____ **SSN:** _____

City: _____ **State:** _____ **Zip:** _____ **Daytime Telephone:** _____

Annuitant of the RCUH Group Retirement Annuity (TIAA GRA) Plan as of (provide date): _____

Are you eligible for Medicare Parts A & B? ☐ Yes ☐ No Part A (Hospital) Effective Date: _____

Have you applied for Medicare Parts A &B? ☐ Yes ☐ No Part B (Medical) Effective Date: _____

Medicare Claim Number: _____

Do you have other coverage? ☐ Yes ☐ No If yes, name of carrier: _____

SECTION II: Retiree Health Insurance Requested Action

REQUESTED ACTION: Please note effective date will be determined by RCUH Human Resources Department.

☐ New Enrollment

☐ Change Enrollment

☐ Cancel Enrollment (effective date: _____)

☐ Cancel Spouse/Civil Union Partner (CUP) Coverage

☐ Automatic Payment

☐ Bill Pay Service

***For changed enrollment(s), please indicate only what will be changed to your current enrollment.**

COVERAGE TIER

☐ Self

☐ 2-Party (Self and Legally Recognized Spouse or Civil Union Partner)

HEALTH INSURANCE PLAN (For Ages 59 ½ to 64)

Self	Spouse/CUP	
☐	☐	HMSA Health Plan Hawai'i **
☐	☐	HMSA Health Plan Hawai'i Plus **
☐	☐	HMSA Preferred Provider HMSA
☐	☐	Comprehensive Medical
☐	☐	Comprehensive Medical Basic
☐	☐	Kaiser Plan B

** **FOR ENROLLMENT IN HMSA HEALTH PLAN HAWAII OR HEALTH PLAN HAWAII PLUS**, you must name a Primary Care Physician and Health Center for you and your spouse/CUP (if applicable):

(Retiree) Primary Care Physician: _____

(Retiree) Health Center: _____

(Spouse) Primary Care Physician: _____

(Spouse) Health Center: _____

HEALTH INSURANCE PLAN (For Ages 65 and over)

Self	Spouse/CUP	
☐	☐	HMSA Akamai Advantage Plan
☐	☐	Kaiser Senior Advantage Plan

Section III: Dependent Information (please attach verification of relationship)

Spouse/CUP Name:_____ **Date of Birth:** _____

SSN:_____

Is your spouse/CUP eligible for Medicare Parts A & B? ☐ Yes ☐ No Part A (Hospital) Effective Date: _____
Has your spouse/CUP applied for Medicare Parts A & B? ☐ Yes ☐ No Part B (Medical) Effective Date: _____
Medicare Claim Number: _____
Does your spouse/CUP have other coverage? ☐ Yes ☐ No If yes, name of carrier: _____

Section IV: Life Insurance Beneficiary Designation Elect (if eligible) ☐ Waive ☐

Complete for retiree life insurance coverage and designation, or change of beneficiary. Must be eligible for RCUH Retiree Life Insurance. ***NOTE:*** *Be advised that life insurance companies will generally not disburse payments directly to minor beneficiaries. Payment will normally be made to the legally recognized guardian of the minor beneficiary, executor of the estate, or RCUH Life Insurance Carrier (see RCUH Policy No. 3.540 for further details on our insurance carrier) will retain the benefit amount until minor attains majority age.* The beneficiary of my RCUH Life Insurance Carrier is:

Primary Beneficiary:_____ **Relationship:** _____

Address:_____ **SSN:**_____ **Date of Birth:**_____

Email:_____ **Phone Number:** _____

Secondary Beneficiary (optional):_____ **Relationship:** _____

Address:_____ **SSN:**_____ **Date of Birth:**_____

Email:_____ **Phone Number:** _____

Applicant Signature:_____ **Date:**_____

Section V: Employee/Retiree's Signature – Please initial and sign

_____I have read and agree to the eligibility requirements for participating in the RCUH Retiree Health and Life Insurance Program. I certify that I am currently an annuitant with the RCUH Group Retirement Annuity (TIAA GRA) plan and will remain so while I am receiving these benefits.
_____Information in this application is given to obtain insurance and is true and complete to the best of my knowledge and belief. I authorize my employer to set my effective dates of coverage. I agree to abide by the provisions of the service agreement and health plan regulations. If I am accepted as an HMSA member, I agree to: (a) abide by HMSA's Constitution and By- laws and the terms and conditions of HMSA's Health Plan; (b) authorize HMSA to examine and copy any medical records of myself and my dependent for purposes of paying benefits, coordinating benefits with other plans, and conducting quality assurance and health education activities. I further understand that the Kaiser Service Agreement provides that any monetary claim asserted by a Member's heirs or personal representatives on account of bodily injury, mental disturbance or death must be submitted to binding arbitration instead of a court trial.

Retiree Signature_____**Date**_____
RCUH will only accept wet signatures and will validate the information prior to processing.

Approved By RCUH Director of Human Resources:_____ _____

☐ Retiree Health + Life Insurance

☐ Retiree Health ONLY

RCUH HR Internal use:

Years of continuous service:_____ Age at time of application: _____ Termination in good standing: _____
10 Years GRA:_____ 10 Years GLIADD:_____ Annuitant with TIAA: _____
Medicare: _____ Verification of Legally Recognized Spouse/CUP (if applicable):_____
Qualified as RCUH Retiree by (Name/Signature):_____ Date:_____

Termination Date: Effective Date of Coverage: HR Input:

Please submit via encrypted email to: rcuh_benefits@rcuh.com or FAX: 808-956-5022

Created 06/2008, (Revised 3/30/2016, 5/3/2018, 5/30/2018, 10/8/2018, 10/16/2018, 03/25/2019, 04/16/2019, 10/17/2019, 10/16/2020, 04/13/2021)