ENROLLMENT/CHANGE FORM

Member—If you are applying for coverage with the First Responders VEBA Trust benefit plan, complete **Sections A-G** below.
If completing by hand, please print clearly. Incomplete and/or illegible forms will be returned.
Proof of membership will be required prior to application acceptance.

A	PLAN SPONSOR NAME **First Responders VEBA Trust**	AFFILIATE ORGANIZATION <Select One>	MEMBERSHIP NUMBER	ACTIVE/RETIREE <Select One>

B	SELECT ONE: ☐ ANNUAL ENROLLMENT ☐ NEWLY ELIGIBLE ☐ QUALIFYING EVENT ☐ CANCELLATION	DATE OF CHANGE	TYPE OF QUALIFYING EVENT <Select if Applicable>	COVERAGE EFFECTIVE DATE

C	MEMBER LAST NAME	MEMBER FIRST NAME	M.I.	SOCIAL SECURITY NUMBER	MEMBER DATE OF BIRTH
	MOBILE PHONE	EMAIL ADDRESS			GENDER ☐ Male ☐ Female
	ADDRESS (Street)	CITY		STATE	ZIP CODE

D

☑ I elect coverage for myself and my dependents

LAST NAME	FIRST NAME	RELATIONSHIP	DEPENDENT SS#	DATE OF BIRTH	GENDER	*DISABLED?
Member		Self	N/A		☐ Male ☐ Female	☐ Yes ☐ No
Dependent		☐ Spouse ☐ Child ☐ Domestic Partner			☐ Male ☐ Female	☐ Yes ☐ No
Dependent		Child			☐ Male ☐ Female	☐ Yes ☐ No
Dependent		Child			☐ Male ☐ Female	☐ Yes ☐ No
Dependent		Child			☐ Male ☐ Female	☐ Yes ☐ No

†Vision coverage included with Medical plan enrollment.
*DEPENDENTS – Dependents are covered to age 26. If totally disabled prior to age 26, attach proof of disability for extended eligibility review.

E

MEDICAL/VISION OPTIONS

Select Plan:

☐ **BASIC PLAN** ☐ **PLUS PLAN** ☐ **ULTRA PLAN** ☐ **BRONZE PLAN** ☐ **SILVER PLAN**

Select Coverage Type:

☐ Member Only
☐ Member + Spouse
☐ Member + Child(ren)
☐ Family

F

ACH AUTHORIZATION

I hereby authorize **Truist Bank** and **Alan J. Zuccari, Inc. dba HBA Administrators** to initiate ACH (Automatic Clearing House) fund transfers from my financial institution listed below and, if necessary, initiate adjustments for any transactions credited/debited in error. If a transaction errors due to insufficient funds, a $25.00 fee will be charged for each unsuccessful attempt. This authority will remain in effect until **HBA Administrators** is notified, in writing, to cancel it in such time as to afford **HBA Administrators** and **Truist Bank** a reasonable opportunity to act on it.

The purpose of these funds is to pay my required monthly contribution for participation in the **First Responders VEBA Trust Benefit Plan**. The monthly transfer of funds will be deducted from my account approximately on the 18th day of the month (adjusted if necessary for weekends/holidays) prior to the month for which coverage is to be provided under the Plan (i.e., September 18th for October coverage invoiced on September 10th).

ACCOUNT OWNER NAME	NAME OF FINANCIAL INSTITUTION
ROUTING NUMBER	ACCOUNT NUMBER
MEMBER SIGNATURE	DATE

Complete Section G before submitting this form

If you have any questions or wish to enroll over the phone, contact the **First Responders Benefit Line** at ***774-RESPOND*** (774-737-7663)

Confidential

MEMBER AUTHORIZATION AND ACKNOWLEDGMENT

I HEREBY: Request enrollment in the self-funded Group Health Plan (the **"Plan"**) established and maintained by the First Responders, Police, Fire and Emergency VEBA (the **"Trust"**) for its eligible Members and their eligible dependents; Represent that I am an eligible Member as defined by the Plan; Represent that my statements and answers to the questions in this enrollment form are true and complete to the best of my knowledge and belief; and Authorize the Plan to collect any required contribution in accordance with the Plan's administrative practices; and Consent to receive informational communications, including electronic mail and SMS text messages, from affiliated service providers supporting the Plan's administration.

I FURTHER ACKNOWLEDGE AND UNDERSTAND: This is not an insured benefit plan; All Plan benefits are self-funded (self-insured) by the Trust; The Trust is solely responsible for all benefit payments; Coverage is not effective until the Plan approves this enrollment form; Plan benefits are available only if a person is covered under, and all required contributions for such coverage have been received by, the Plan; If I have waived coverage for a dependent, I also waive all claims under the Plan for benefits for that dependent, and if I decide to enroll that person at a later date, the effective date for my dependent will be subject to the Annual Open Enrollment and/or Qualifying Event provisions as defined by the Plan. A full description of the medical expense benefits under the Plan appears in the Summary Plan Description, which summarizes the official Plan Document; The agent submitting this enrollment lacks authority to change the enrollment form, approve Plan coverage, alter Plan terms, or adjust claims; The Reinsurer, The Program Manager, The Broker, The GA, The MGA or the TPA is not responsible for funding benefit payments; My statements and answers in this enrollment form will be the basis for approving Plan coverage and any material misrepresentation or omission may result in an increase in Plan contribution rates or termination of my coverage; Any person who, knowingly and with intent to defraud, submits an enrollment form, or files a claim, containing a materially false statement, or omitting materially false information, may be found guilty of fraud in a court of law.

SPECIAL ENROLLMENT RIGHTS: If you acquire a new dependent by marriage, birth, adoption or placement for adoption, he/she may be able to enroll without delay or penalty, if you request enrollment within 31 days (of the marriage, birth, adoption or placement for adoption); If you decline enrollment for any dependent (including your spouse) because of other health plan or group insurance coverage, and that dependent subsequently becomes ineligible for the other coverage (or the employer stops contributing towards that coverage), he/she may be able to enroll without delay or penalty, if you request enrollment within 31 days of ineligibility or termination of employer contributions; If you decline enrollment for any dependent (including your spouse) because of coverage under Medicaid or a State child health plan, and that dependent's coverage is subsequently terminated due to ineligibility, he/she may be able to enroll without delay or penalty, if you request enrollment within 60 days of the termination of coverage; If you decline enrollment for any dependent (including your spouse) and that dependent subsequently becomes eligible for a premium assistance subsidy from Medicaid or a State child health plan, he/she may be able to enroll without delay or penalty, if you request enrollment within 60 days of eligibility for the subsidy. To request special enrollment contact the Plan Administrator.

PERSONAL INFORMATION NOTICE: As required by law, this notice is intended to inform you that 1) Personal information may be collected from third parties; 2) Such information as well as other personal or privileged information collected by the health plan or its legal representative may be in certain instances, as prescribed by law, disclosed to other third parties without your prior authorization; 3) You have the right to access and correct the collected information; 4) Your right to access does not include any information which relates to and is collected in connection with, or in reasonable anticipation of, a claim or civil or criminal proceeding; 5) We will provide a more detailed notice of information practices upon request.

G

AUTHORIZATION FOR RELEASE OF INFORMATION: I authorize the disclosure of all nonpublic personal information and individually identifiable protected health information for me (and my dependent(s), if applicable), including but not limited to employment status, other health plan coverage, diagnosis, prognosis, medical treatment or care, and physical or mental conditions (including alcohol or drug dependency), by any physician, medical practitioner, hospital, other medical related facility, insurance company, employer or benefit plan having such information, to the health plan or its legal representative, agent or vendor, for the purpose of processing enrollment and claims. I acknowledge and agree that this authorization shall be valid for two (2) years; that I may revoke it in writing at any time; that I may request a copy of this authorization; that enrollment, but not the processing of claims, is conditioned on my signing this authorization; that this authorization will be used as its own document, separate from the enrollment form; that a photocopy of this authorization shall be as valid as the original; that any documentation or information disclosed pursuant to this authorization may be redisclosed and may no longer be covered by federal or state privacy laws; and that I have authority to act as the personal representative of my dependent(s) (if requesting dependent coverage).

I also hereby authorize any physician, medical practitioner, hospital, clinic, Veterans administrations facility, other medical or medically related facility, insurance or reinsurance company, pharmacy, pharmacy benefit manager, health plan, or Consumer Reporting Agency, having information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition, including drug or alcohol abuse, as well as diagnosis, treatment, and testing results related to HIV, AIDS, and sexually transmitted diseases, and/or treatment of me or my minor children and other nonmedical information of me and my minor children, to release to the claims or third party administrator, any other excess loss insurance carrier designated by the Plan, or its legal representative, any and all such information as required for determination of eligibility for benefits. I also understand that my dependents of legal age, in order to be eligible for benefits, may be required to sign a similar release of medical records for the purpose of determining the accuracy of statements made by me on this form and for the ultimate determination of eligibility for benefits under the Plan. I understand that I may request a copy of this authorization at any time. I understand that any information that is disclosed pursuant to this authorization may be re-disclosed and no longer covered by federal rules governing privacy and confidentiality of health information.

I agree that a photographic copy of this authorization shall be as valid as the original, and that this authorization shall be valid for two and one-half (2.5) years from the date shown below. I understand the information obtained by use of this authorization may be used by the Plan Sponsor, claims or third party administrator, and any excess loss insurance carrier designated by the Plan to determine eligibility for coverage. Any information obtained will not be released to any person or organization, except to reinsuring companies or other persons or organizations performing business or legal services in connection with my enrollment for the coverage, for any claim, for medical management purposes, or as may be otherwise lawfully required or as I may further authorize. I also understand that I have a right to revoke this authorization in writing at any time, except to the extent information has been released in reliance upon this authorization. Failure to sign this Authorization, or subsequent revocation of this Authorization, may impair the ability of the underwriter to process your application/enrollment or evaluate claims, and may be a basis for denying an application or claim for benefits; however, your ability to receive health care services will not be changed if you do not sign this Authorization. All pages must be attached and complete, including this authorization for the statement to be considered complete. Incomplete statements may be rejected.

I have read the above and acknowledge my understanding of, and authorization to, the requirements for Plan participation.

Member Signature _____ **Date:** _____

Return completed forms ***along with an image of your active affiliate membership card*** (i.e., FOP Card, IAFF Card, Membership Letter, etc.) to:

Via email: ***FREnrollment@HBAAdministrators.com***