

**National Professional Retirees Insurance Trust
Plan I
Retiree Medical Insurance Plan Enrollment Form
Underwritten by: Monumental Life Insurance Company, Cedar Rapids, IA**

You Must Return Your Enrollment Form To Put Your Coverage In Force!

Please Print

Retiree Information:

Name: _____ Date of Birth: Month/_____/Day ____/Year _____
Address: _____ Social Security Number: _____
City: _____ Medicare Number: _____
State: _____ Zip Code: _____ Sex: _____ Phone Number: (_____) _____
Email Address: _____ Desired Effective Date: _____

Spouse Information:

Name: _____ Date of Birth: Month/_____/Day ____/Year _____
Address: _____ Social Security Number: _____
City: _____ Medicare Number: _____
State: _____ Zip Code: _____ Sex: _____ Phone Number: (_____) _____
Email Address: _____ Desired Effective Date: _____

Please Choose Type of Coverage:

Retiree
 Plan I

Retiree and Spouse
 Plan I

Spouse Only
 Plan I

Please Complete the Following Information:

Do you currently have any Medicare Supplement policies or certificates in force (including Health Maintenance Organization contract or Health care service contract)?

Retiree (if enrolling): Yes No **Spouse (if enrolling):** Yes No

- (a) If YES*, with which company? _____
(b) What kind of policy/certificate? _____
(c) Length of time you have had coverage? _____ Years _____ Months
(d) Will you be replacing the above listed policy/certificate upon acceptance of this enrollment form? Yes No

*I understand it is my responsibility, if I desire to do so, to cancel my current coverage, if any, by notifying the Provider or Plan Administrator of such coverage.

(Over please)

Please Sign and Date:

I/We hereby enroll in the National Professional Retirees Insurance Trust Retiree Medical Insurance Plan provided under group Policy Form number LM1000GPM, LM1000GPM.PA issued by Monumental Life Insurance Company. I/We am/are 65 or over and covered by Medicare Parts A & B. I/We understand this insurance will be effective on the date shown on the certificate schedule.

FRAUD WARNING

AR, CO, DC, KY, LA, ME, NM, OH, OK, TN and WA Residents: Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a crime and may be subject to fines or confinement in prison.

NJ Residents: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

PA Residents: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Retiree Signature: _____

Date: _____

Spouse Signature: _____

Date: _____

Mail your completed enrollment form in the return envelope provided.

For customer service: call 1-888-883-3757, Monday through Friday, 8:00 a.m. to 8:00 p.m.,
Eastern Time.

**National Professional Retirees Insurance Trust
Plan II
Retiree Medical Insurance Plan Enrollment Form
Underwritten by: Monumental Life Insurance Company, Cedar Rapids, IA**

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Please Print

Retiree Information:

Name: _____ Date of Birth: Month/_____/Day ____/Year _____
Address: _____ Social Security Number: _____
City: _____ Medicare Number: _____
State: _____ Zip Code: _____ Sex: _____ Phone Number: (_____) _____
Email Address: _____ Desired Effective Date: _____

Spouse Information:

Name: _____ Date of Birth: Month/_____/Day ____/Year _____
Address: _____ Social Security Number: _____
City: _____ Medicare Number: _____
State: _____ Zip Code: _____ Sex: _____ Phone Number: (_____) _____
Email Address: _____ Desired Effective Date: _____

Please Choose Type of Coverage:

Retiree
 Plan II

Retiree and Spouse
 Plan II

Spouse Only
 Plan II

Please Complete the Following Information:

Do you currently have any Medicare Supplement policies or certificates in force (including Health Maintenance Organization contract or Health care service contract)?

Retiree (if enrolling): Yes No **Spouse (if enrolling):** Yes No

- (a) If YES*, with which company? _____
(b) What kind of policy/certificate? _____
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