



MEDICARE ELECTION FORM

FOR: **A. ACTIVE EMPLOYEES** – AGES 65 OR OLDER
B. SPOUSES – AGES 65 AND OLDER OF ACTIVE EMPLOYEES OF ANY AGE

A. PLEASE COMPLETE THIS FORM ENTIRELY (SEE THE REVERSE SIDE FOR INSTRUCTIONS):

1. PLAN NAME: _____

Dear employee/spouse:

You are required to elect whether you want medicare or the above plan to be your primary health coverage.

If you elect Medicare, the above plan will not provide any secondary benefits and your health benefits under the above plan will terminate. You may not be eligible to enroll in the plan at a later date or you may be subject to late enrollment provisions.

If you elect the above plan, Medicare may provide benefits as a secondary payer. You are advised to keep your Medicare plan (Parts A & B) in force, as failure to do so may leave you without health coverage should your benefits terminate under the above plan.

Please review your Summary Plan Description/Plan Document booklet and complete the following. Should you have any questions, please contact our office at: BUSINESS ADMINISTRATORS & CONSULTANTS, INC., P.O. Box 107, Reynoldsburg, OH 43068-0107, or call 1.800.521.2654.

B. EMPLOYEE:

2. EMPLOYEE'S NAME (LAST, FIRST, M.): _____ DATE OF BIRTH (MM/DD/YYYY): _____ SOCIAL SECURITY NUMBER: _____

3. CHOOSE ONE:
 I DO NOT HAVE A SPOUSE.
 I AM MARRIED BUT DO NOT COVER ANY SPOUSE AS A DEPENDENT.
 I AM MARRIED AND COVER MY SPOUSE. SPOUSE'S DATE OF BIRTH: _____ (IF AGE 65 OR OLDER, COMPLETE C).

4. ELECTION:
I UNDERSTAND I AM REQUIRED TO ELECT WHETHER I WANT MEDICARE OR MY EMPLOYER'S PLAN AS MY PRIMARY HEALTH COVERAGE. I HAVE READ MY EMPLOYER'S PLAN AND I ELECT: MEDICARE EMPLOYER PLAN

5. THIS ELECTION SHALL NOT INVALIDATE THE COORDINATION OF BENEFITS OR SUBROGATION PROVISIONS IN THE EMPLOYER PLAN AS THEY RELATE TO PLANS OTHER THAN MEDICARE.:

X _____ DATE SIGNED (MM/DD/YYYY): _____
 EMPLOYEE'S SIGNATURE (NOT VALID UNLESS SIGNED IN INK):

X _____ WITNESS' NAME (PLEASE PRINT LEGIBLY):
 WITNESS' SIGNATURE (NOT VALID UNLESS SIGNED IN INK):

C. SPOUSE:

6. SPOUSE'S NAME (LAST, FIRST, M.): _____ DATE OF BIRTH (MM/DD/YYYY): _____ SOCIAL SECURITY NUMBER: _____

7. ADDITIONAL INFORMATION:
 I AM PRESENTLY EMPLOYED. EMPLOYER'S NAME: _____
 I AM PRESENTLY COVERED BY A HEALTH PLAN OTHER THAN MY SPOUSE'S OR MEDICARE. NAME OF PLAN: _____

8. ELECTION:
I UNDERSTAND I AM REQUIRED TO ELECT WHETHER I WANT MEDICARE OR MY SPOUSE'S EMPLOYER'S PLAN AS MY PRIMARY HEALTH COVERAGE. I HAVE READ MY SPOUSE'S EMPLOYER'S PLAN AND I ELECT: MEDICARE EMPLOYER PLAN

9. THIS ELECTION SHALL NOT INVALIDATE THE COORDINATION OF BENEFITS OR SUBROGATION PROVISIONS IN THE EMPLOYER PLAN AS THEY RELATE TO PLANS OTHER THAN MEDICARE.:

X _____ DATE SIGNED (MM/DD/YYYY): _____
 SPOUSE'S SIGNATURE (NOT VALID UNLESS SIGNED IN INK):

X _____ WITNESS' NAME (PLEASE PRINT LEGIBLY):
 WITNESS' SIGNATURE (NOT VALID UNLESS SIGNED IN INK):

INSTRUCTIONS:

Complete form in the month when:

- I. Employee becomes age 65.
- II. Spouse of any covered employee becomes age 65.
- III. Hiring a new employee age 65 or older who will be eligible for the health benefit plan.
- IV. Hiring any new employee whose spouse is age 65 or older and the employee will be eligible for the health benefit plan.
- V. Any benefits for all other employees under age 65 are changed, or the employees under age 65 have the right to change, add to, or modify their health benefits.

Form to be completed by:

- A) Employees age 65 or older: Complete 1 through 5, and sign section B.
- B) Spouses age 65 or older: Complete 1 through 9, and sign section C.

Employer/Plan Sponsor:

Each employee should be given a Summary Plan Description/Plan Document booklet when making their Election. You should keep a copy of the completed form for your records.

Send completed form to:

BUSINESS ADMINISTRATORS & CONSULTANTS, INC.
P.O. Box 107
Reynoldsburg, Ohio 43068-0107

FOLD HERE FOR USE WITH A NO. 10 WINDOW ENVELOPE



FEEL FREE TO CONTACT US WITH ANY QUESTIONS OR COMMENTS:

ON THE WEB: **WWW.BACTPA.COM**

TOLL FREE: **1.800.521.2654**

FACSIMILE: **1.614.863.0184**

**ANSWER ALL QUESTION FULLY,
AND MAIL TO BAC FOR PROCESSING:**

BUSINESS ADMINISTRATORS & CONSULTANTS, INC.
PO BOX 107
REYNOLDSBURG, OH 43068-0107