STATE OF CONNECTICUT
TEACHERS' RETIREMENT BOARD
765 ASYLUM AVENUE HARTFORD, CT 06105-2822
Toll free 1-800-504-1102 (860) 241-8400 Fax (860) 622-2849
"An Affirmative Action/Equal Opportunity Employer"
www.ct.gov/trb

October 2009

MEDICARE SUPPLEMENTAL HEALTH INSURANCE CHANGE FORM FOR JANUARY 1, 2010

Health Coverage Change Requirements

This is your annual opportunity to add, drop or cancel health insurance coverage through CTRB.

If you are making changes to your health coverage the attached form must be at CTRB by November 15, 2009.

Each insured person covered under the TRB health plan who wants to add, drop or cancel their coverage must submit one change form. Two change forms are enclosed; one for the member and one for the spouse or civil union partner; if applicable. Once you enroll in a specific plan, no changes are allowed until January 2011.

PLEASE NOTE: The Teachers' Retirement Board Pharmacy Benefit Manager will not be MEDCO after February 2010. The Board is in the process of selecting a new vendor. The deductible will be administered concurrent with the change in vendors. You will receive a new member package and new prescription cards from the selected vendor.

New Rates Effective January 1, 2010

Coverage Type	Monthly, Per Person
Medicare Supplement with Prescriptions	$112.00
Medicare Supplement with Prescriptions & Dental	$160.00
Medicare Supplement with Prescriptions, Dental, Vision & Hearing	$165.00

PLEASE NOTE:

- **Diabetic Supplies (Test Strips, Lancets, and Monitors)** should be purchased at a retail pharmacy or a diabetic supply company, who will submit the charges to Medicare for payment.
- **Prescription Wigs** will be covered by Stirling Benefits beginning January 1, 2010.
- The CT Teacher's Retirement Board (TRB) will coordinate benefits for members who have other health insurance consistent with the NAIC coordination of benefit rules. However, since we sponsor a Medicare supplement plan with prescription coverage and receive a federal reimbursement, we cannot allow a member to participate in our program and participate in a Medicare D program, Medicare advance program or the prescription program of another employer who also receives the federal reimbursement. To find out if another prescription program receives the federal reimbursement you must contact the benefits department of the other employer.
- All address changes must be reported to the TRB who will inform the vendors.
- The Delta Dental ID number is 45780003.

PLEASE RETAIN THIS DOCUMENT

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HEALTH INSURANCE CHANGE FORM
RETIREE

This form is to be completed by members who are currently enrolled in a TRB Health Plan and are adding, dropping or canceling coverage.

- SUBMIT A COPY OF YOUR MEDICARE CARD EVEN IF YOU ARE CURRENTLY ENROLLED IN A STIRLING BENEFITS PLAN AND WISH ONLY TO CHANGE YOUR COVERAGE.
- ONE FORM FOR EACH PERSON CHANGING COVERAGE MUST BE RECEIVED BY November 15, 2009.
- All changes will be effective JANUARY 1, 2010.
- **DO NOT SUBMIT THIS FORM IF YOU ARE STAYING IN YOUR CURRENT PLAN**.

	Cost per person per month	**Check one(x)**
Medicare Supplement with Prescriptions	$112.00	☐
Medicare Supplement with Prescriptions and Dental	$160.00	☐
Medicare Supplement with Prescriptions and Dental, Vision & Hearing	$165.00	☐
Cancel all TRB coverage effective January 1, 2010		☐

If you will retain supplemental coverage other than Medicare A & B and Stirling, please check this box. ☐

ALL ENROLLEES MUST PROVIDE THE FOLLOWING INFORMATION:

Enrollee's Last Name First Name Initial		Home Phone
Street Address City State Zip Code		Email Address
Social Security Number	Medicare Number	Date of Birth

PREMIUMS ARE DEDUCTED MONTHLY FROM THE MEMBER'S RETIREMENT BENEFIT.

Enrollee's Signature	Date

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HEALTH INSURANCE CHANGE FORM
SPOUSE OR CIVIL UNION PARTNER

This form is to be completed by spouses or civil union partners who are currently enrolled in a TRB Health Plan and are adding, dropping or canceling coverage.

- SUBMIT A COPY OF YOUR MEDICARE CARD EVEN IF YOU ARE CURRENTLY ENROLLED IN A STIRLING BENEFITS PLAN AND WISH ONLY TO CHANGE YOUR COVERAGE.
- ONE FORM FOR EACH PERSON CHANGING COVERAGE MUST BE RECEIVED BY November 15, 2009.
- All changes will be effective JANUARY 1, 2010.
- **DO NOT SUBMIT THIS FORM IF YOU ARE STAYING IN YOUR CURRENT PLAN**.

	Cost per person per month	**Check one(x)**
Medicare Supplement with Prescriptions	$112.00	☐
Medicare Supplement with Prescriptions and Dental	$160.00	☐
Medicare Supplement with Prescriptions and Dental, Vision & Hearing	$165.00	☐
Cancel all TRB coverage effective January 1, 2010		☐

If you will retain supplemental coverage other than Medicare A & B and Stirling, please check this box. ☐

ALL ENROLLEES MUST PROVIDE THE FOLLOWING INFORMATION:

Enrollee's Last Name First Name Initial		Home Phone
Street Address City State Zip Code		Email Address
Social Security Number	Medicare Number	Date of Birth

PREMIUMS ARE DEDUCTED MONTHLY FROM THE MEMBER'S RETIREMENT BENEFIT.

Enrollee's Signature	Date

If you are enrolling as the spouse or civil union partner of a retired teacher, please furnish the following:

Retired Teacher's Name	Retired Teacher's Social Security #	Retiree's Signature