EXPRESS SCRIPTS®

Senior Medical Insurance Plan Enrollment Form

Hartford Life & Accident Company

☐ Accept Coverage ☐ Decline Coverage

Name of Participating Firm (Employer): ______________________ Policy #: ______________________

Please print name EXACTLY as it appears on your Medicare card.

Retiree's Name: ____
(First) (Middle) (Last)

Street Address/Mailing Address: ____

City, State, Zip: ______________________ Phone #: ______________________

Sex: ☐ Male ☐ Female Date of Birth: ____/____/____ Social Security Number: ______________________

Medicare Number: ______________________ Date of Retirement (if applicable): ______________________

Date Eligible for Medicare*: ______________________

*If you are already covered by Medicare, please include a Certificate of Creditable Coverage from your current insurance carrier with this application.

Please print name EXACTLY as it appears on your Medicare card.

Spouse's Name (only if enrolling): ____
(First) (Middle) (Last)

Street Address/Mailing Address: ____
City, State, Zip: Phone #:

Sex: ☐ Male ☐ Female Date of Birth: ____/____/____ Social Security Number: ______________________

Medicare Number: ______________________ Date Eligible for Medicare*: ______________________

*If you are already covered by Medicare, please include a Certificate of Creditable Coverage from your current insurance carrier with this application.

Date: ______________________ Retiree Signature: ______________________

Date: ______________________ Spouse Signature: ______________________