**LAKE COUNTY HUMAN RESOURCES DEPARTMENT**
LAKE COUNTY GOVERNMENT CENTER
2293 NORTH MAIN STREET
CROWN POINT, IN 46307

Congratulations on your plans to retiree! If you have reached the service years and time you are eligible to apply for retiree benefits as offered through the Lake County insurance plan. Your coverage will include Medical, Dental, Vision, and prescription coverage. Listed below is a breakdown of the retiree insurance premiums:

**The New Rates for Retired Employees is as follows:**

- **Under Age 65 Single- $170.00 Per Month**
- **Under Age 65 Family- $260.00 Per Month**
- **65 & Over Single- $100.00 Per Month**
- **65 & Over Family- $185.00 Per Month**

## PAYMENTS WILL BE TAKEN OUT ON THE 15TH OF EVERY MONTH

Retirees and dependents must carry Medicare A & B when eligible. Your life insurance benefits as a retiree will be $5,000.00 death benefit for basic life only until you reach age 70. No AD&D (accidental death and dismemberment) nor dependent life benefits are available for retirees. If you require more information concerning our current life insurance amount, please call our office at 219-755-3212 during the hours of 8:30am to 4:30pm.

# RETIREE INSURANCE CONTINUATION FORM

NAME DATE OF BIRTH LAST FOUR SSN

SPOUSE NAME DATE OF BIRTH LAST FOUR SSN

[ ] I WILL CONTINUE ON INSURANCE AFTER MY RETIREMENT

[ ] I WILL NOT CONTINUE ON INSURANCE AFTER MY RETIREMENT

ADDRESS

TELEPHONE NUMBER CELL PHONE NUMBER

TO BE COMPLETED BY INSURANCE:

HIRE DATE TERMINATION DATE

LAST PAY DATE

AMOUNT OF PREMIUM FREE AFTER 65? YES NO CIRCLE ONE

COVERAGE EFFECTIVE DATE

NOTE: IT IS THE RETIREE'S RESPONSIBILITY TO NOTIFY INSURANCE WHEN HE/SHE TURNS 65.

# AUTHORIZATION FOR DIRECT PAYMENT VIA ACH

I authorize the LAKE COUNTY TREASURER to electronically debit my below listed account (and, if necessary, electronically credit my account to correct erroneous errors) as follows:

**[ ] Checking Account / [ ] Savings Account (select one) at the depository institution named below. I agree that the ACH transaction I authorize complies with all applicable law.**

**DEPOSITORY NAME** _____

**ROUTING NUMBER** _____

**ACCOUNT NUMBER** _____

**AMOUNT OF DEBIT** _____

**START DATE** _____ **FREQUENCY: MONTHLY**

I understand this authorization will remain in full force and effect until I notify the LAKE COUNTY TREASURER or LAKE COUNTY INSURANCE DEPARTMENT in writing that I wish to revoke this authorization. I understand that LAKE COUNTY requires at least thirty (30) days prior notice to cancel this authorization.

NAME PRINTED: _____

SIGNATURE: _____

DATE: _____

RETURN FULLY COMPLETED FORM IN PERSON OR BY MAIL TO:

LAKE COUNTY BOARD OF COMMISSIONERS

INSURANCE DEPARTMENT

2293 N. MAIN ST.

CROWN POINT, IN 46307

# LAKE COUNTY HUMAN RESOURCES DEPARTMENT

**Danielle D. Royster, MBA, Human Resources Director**
LAKE COUNTY GOVERNMENT CENTER
2293 NORTH MAIN STREET
CROWN POINT, IN 46307


To: Lake County Government Retirees

From: Lake County Board of Commissioners

RE: Life Insurance Past the Age of 70

Dear Retirees:

The Lake County Board of Commissioners is offering our Lake County retirees an opportunity to continue their life insurance. **For a premium of $60.00 pre year, a retiree may continue to have $5,000 for life insurance after the age of 70 for the rest of retiree's life, if the retiree meets the following criteria.**

- You must have 25 years of continuous service
- You must be over the age of 65

If you are interested please contact Rickeyta Dancy in the Lake County Human Resource Department. A payment of $60.00 payable to "Lake County Board of Commissioners" will be required.

Please feel free to call 219-755-3212 if you should have any questions.

Sincerely,

Rickeyta Dancy
Benefits Coordinator

# Lake County Government
# Aetna Enrollment Form

**CONFIDENTIAL**
Benefits Enrollment Form

## Section 1 – Member Information

| | | |
|---|---|---|
| Last Name First Name | | Employer Name<br>**Lake County Government**<br>Control Number **891192** Suffix **10** |
| Address City<br>State Zip Code | | Employer Address<br>**2293 N Main St, Crown Point, IN 46307** |
| Social Security Number | Gender (Circle One): Male / Female | Type of Coverage<br>**Retiree** |
| Date of Birth | Home Phone Number | Plan Option (Choose from below) |
| Medicare Number | | 2271: AA (Formerly plan B)<br>Plan 101 ($150 deductible)<br><br>2286: AB (Formerly plan F)<br>Plan 102 (No deductible) |
| Effective Date: | | |
| Aetna Member ID Number (if available) | | |
| Are you applying as a dependent of an eligible retiree YES/NO (Circle one)<br>If yes, please list first and last name of retiree: | | |

## Section—5 Acknowledgement and Authorization

I acknowledge that by enrolling in an Aetna plan, coverage is underwritten or administered by Aetna Life Insurance Company, Aetna Health Inc. and/or Aetna Health insurance Company (referred to as "Aetna"). For Vision coverage, First American Administrators, Inc. provides certain claims administration services. EyeMed Vision Care, LLC ("EyeMed") provides certain network administration services.

1. My employer's application determines coverage. I don't have coverage until Aetna approves my employee enrollment form and the employer application. Even if Aetna approves the employer application, material misstatements or omissions may result in denial of future claims. Aetna may rescind or reevaluate my coverage under the policy, as of the effective date, for eligibility and rating purposes. If Aetna voids or rescinds coverage, I may be entitled to a refund of any paid premiums from the effective date of coverage. Aetna will give at least 30 days advance written notice to any covered person affected by the proposed rescission. If I elect to receive electronic notifications, I will receive this notice in an electronic (email) format.

2. To support the coverages listed on this enrollment form, Aetna may need information about medical history, services or treatment provided to anyone listed on this form. This may include minimally necessary information about mental health, substance use disorder and HIV/AIDS. In accordance with HIPAA regulations, I authorize that the following entities can provide this information to Aetna or its agents:
   - Physicians
   - Other healthcare professionals
   - Hospitals
   - Other healthcare organizations ("providers"), including
     - Pharmacies
     - Pharmacy database benefit managers
3. In accordance with HIPAA regulations, I authorize Aetna to use and disclose such minimally necessary information to:
   - Affiliates
   - Providers
   - Other insurers
   - Third party administration
   - Vendors
   - Consultants
   - Governmental authorities with jurisdiction when necessary for:
     - Care or treatment
     - Payment for services
     - Operation of my health plan
     - Conduct related activities
4. I discussed the terms of this authorization with my competent adult dependents. This authorization is valid for 30 months from the signature date. This authorization is valid for the term of the coverage for medical information collected in connection with a medical claim. This authorization is voluntary. But if I don't sign this form, my ability to enroll in the plan may be affected. I have the right to revoke this authorization in writing to Aetna at any time. I can't revoke authorization for information already used or disclosed before I revoked my authorization. I am entitled to receive a copy of this authorization upon request. A photocopy is as valid as the original.
   - The Group Agreement/Group Policy determines the rights and responsibilities of members and will govern in the event they conflict with any:
     - Benefits comparison
     - Summary
     - Other description of the plan
   - Participating physicians, hospitals and other health care providers are independent contractors. They are not Aetna agents or employees. We cannot guarantee the availability of any particular provider. Any provider network is subject to change. We will provide a notice of the change in accordance with applicable state law.
5. I understand that, with certain exceptions described in the plan documents, HMO and DMO® plans only provide coverage for covered benefits. The plan documents also describe if I need a referral for certain procedures, and who can provide care. Covered services must be performed by:
   - Participating primary care physicians
   - Participating primary care dentists
   - Participating specialists
   - Participating hospitals
   - Participating pharmacies
   - Participating dentists
   - Other participating providers as authorized by a referral from a participating primary care physician
6. I authorize the substitution of generic pharmaceuticals for the brand-name products, as provided by law, for prescriptions filled under any pharmacy benefit.

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I represent that all information supplied in this form is true and complete to the best of my knowledge and belief. I agree to the conditions of enrollment and misrepresentation statement on this Employee Enrollment Form. I understand that, if I don't sign this form within 31 days, or Aetna does not receive the request within a reasonable time, my eligibility may be affected.

I authorize deductions from my earnings for any contributions required for coverage and I agree to make any necessary payments required for coverage.

**To receive documents online, please visit your secure member account at Aetna.com.**

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**Misrepresentation: 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.**

| Employee's Printed Name | Employee's Signature | Date |
|---|---|---|
| | | |