Please return completed enrollment form to:
Boon Administrative Services, Inc.
Attn: Benefits Administration
6300 Bridgepoint Parkway, Building 3, Suite 500
Austin, TX 78730

or email completed form to:
DeltaRetireeEF@boongroup.com
or fax completed form to:
512-339-6662 Attention: Delta Retiree EF

Effective Date: ____/01/2011

Group Name: DP3 VEBA Trust

DP3 VEBA Trust Medicare Eligible Enrollment Form

SECTION 1	RETIREE INFORMATION	
Retiree Name (Last, First, MI):	HIC#/Medicare ID:	Social Security #:
Home Mailing Address:	Date Of Birth:	Sex: ☐ Male ☐ Female
City, State, Zip:	E-mail Address:	Home Telephone Number:

SECTION 2	COVERAGE INFORMATION
☐ **Option 1: Medical + Pharmacy + Dental + Premium Vision (includes a TPA fee of $8.89)** ☐ Retiree/Surviving Spouse/ or Spouse Only ☐ Retiree + Spouse	☐ **Option 2: Medical + Pharmacy + Dental + Basic Vision (includes a TPA fee of $8.89)** ☐ Retiree/Surviving Spouse/ or Spouse Only ☐ Retiree + Spouse
☐ **Option 3: Medical + Pharmacy + Dental (includes a TPA fee of $8.89)** ☐ Retiree/Surviving Spouse/ or Spouse Only ☐ Retiree + Spouse	☐ **Option 4: Medical + Pharmacy (includes a TPA fee of $8.44)** ☐ Retiree/Surviving Spouse/ or Spouse Only ☐ Retiree + Spouse
☐ **Option 5: Medical + Pharmacy + Premium Vision (includes a TPA fee of $8.89)** ☐ Retiree/Surviving Spouse/ or Spouse Only ☐ Retiree + Spouse	☐ **Option 6: Medical + Pharmacy + Basic Vision (includes a TPA fee of $8.89)** ☐ Retiree/Surviving Spouse/ or Spouse Only ☐ Retiree + Spouse
☐ **Option 7: Dental + Premium Vision (includes a TPA fee of $6.99)** ☐ Retiree/Surviving Spouse/ or Spouse Only ☐ Retiree + Spouse	☐ **Option 8: Dental + Basic Vision (includes a TPA fee of $6.99)** ☐ Retiree/Surviving Spouse/ or Spouse Only ☐ Retiree + Spouse

Important Notes To Help You Correctly Select and Complete Your Coverage Elections

- **The Plan F Medical Rates are "attained age" rates based upon your age and your zip code. Please contact the administrator, The Boon Group @ 1-866-868-9006 to obtain your individual Plan F rates. Please review the total rates for each plan before making your election.**
- **Make sure to indicate the month you would like your coverage to begin. Coverage can only become effective on the 1st day of the month, and the effective date cannot be retroactive – it must be some time in the future.**
- **Please review all information and sign and date where necessary.**
- **It is not necessary to include a payment with your initial enrollment form, the Boon Group will send you an invoice after you have successfully enrolled.**
- **Total rates include the Third Party and VEBA Trust Administrative Fees.**
- **It is important to remember that there is no subsidy available for the Over 65 program for Delta Retirees through the DP3 VEBA Trust Plans. The only exception would be the Part B premium reimbursement for the Pre-1997 retirees.**

Note: To be eligible for the Medical and Pharmacy coverage, you must be receiving both Medicare Parts A & B.

For information on the available Non-Medicare benefits for Eligible Delta Beneficiaries, please call 1-877-928-VEBA (8322).

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SECTION 3 DEPENDENT INFORMATION ☐ **(Additional Dependent Info Attached)**

List full name of Dependent to be covered under Medical, Dental, Vision, and Pharmacy as applicable.

Dependent's Name (Last, First, MI)	HIC#/Medicare ID:	Social Security #:	Date of Birth	Sex	Coverage/s
				☐ Male ☐ Female	☐ Medical /Rx ☐ Dental ☐ Vision

SECTION 4 RETIREE AUTHORIZATION AND SIGNATURE

Release of Information:
By joining this prescription drug plan, I acknowledge that my information will be released to Medicare and other plans as is necessary for treatment, payment and health care operations. The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information, I will be disenrolled from this plan.

I understand that my signature (or signature of the person authorized to act on behalf of the individual under the laws of the State where the individual resides) on this application means that I have read and understand the contents of this application. If signed by an authorized individual (as described above), this signature certifies that: 1) this person is authorized under State law to complete this enrollment and 2) documentation of this authority is available upon request by applicable plan vendors or by Medicare.

Notification:

Medical Enrollment: Residents of all states except Florida: Your signature acknowledges you understand that the Aetna Supplemental Retiree Medical Plan is not a Medicare Supplement insurance plan or Medigap plan. Enrollment in Medicare Parts A and B is required. Please note that CHCS Services, Inc. is currently the third party administrator for the Aetna Supplemental Retiree Medical Plan. NOTE: In the states of New York and Kentucky, the name of this group health product is the "Aetna Retiree Medical Plan". In the state of Kansas, the name of this group health product is the "Aetna Retiree Medical Insurance Plan". In all other states, the name of this group health product is the "Aetna Supplemental Retiree Medical Plan".*

Florida residents: The Aetna Group Medicare Supplement Insurance Plan is a Medicare Supplement insurance plan. Please note that CHCS Services, Inc. is currently the third party administrator for the Aetna Group Medicare Supplement Insurance Plan.

Attestation:
Your signature is verification that:

- You are an Eligible Delta Air Lines Beneficiary and can supply supporting documentation upon request.
- You are enrolled in both Medicare Parts A and B.

FRAUD WARNING

Any person who, knowingly and with intent to defraud any insurance company or other persons: (1) files an application for insurance or statement of claim containing any materially false information; or (2) conceals for the purpose of misleading, information concerning any material fact thereto, commits a fraudulent insurance act.

Retiree Signature ______________________ Date ______________________