

NH School Health Care Coalition
SCHOOLCARE 65+
Retiree Medical Plan Enrollment Form

PLEASE PRINT

PARTICIPANT INFORMATION

Name _____ Date of Birth _____ Sex _____
Last First MI

Address _____ Phone No. (____) _____

City _____ State _____ Zip _____ Social Security No. _____

Medicare Claim Number _____ (From Medicare Card)

Please include photocopy of your Medicare Part B card for verification of coverage.

Check here if you wish to **decline** pharmacy coverage.

SPOUSE INFORMATION (if to be covered)

Name _____ Date of Birth _____
Last First MI

Social Security No. _____

Medicare Claim Number _____ (From Medicare Card)

Please include photocopy of your Medicare Part B card for verification of coverage.

Check here if you wish to **decline** pharmacy coverage.

I hereby enroll in the NH School Health Care Coalition – **SCHOOLCARE 65+** Retiree Medical plan underwritten by United American Insurance Company. I and my spouse (if to be covered) are enrolled in Medicare Parts A & B. Furthermore, I understand that I cannot be enrolled in Medicare Part D unless I have declined pharmacy coverage above. I understand that this insurance will be effective on the date shown on the certificate schedule.

Applicant's Signature

Date

Spouse's Signature (if to be covered)

Date

Policy Effective Date:

Former Employer:

RETURN COMPLETED APPLICATION TO:
NH School Health Care Coalition – SchoolCare
370 Harvey Road, Suite 4
Manchester, NH 03103
800-562-5254