COALITION OF DETROIT PUBLIC SAFETY UNIONS TRUST (CDPSU)
ENROLLMENT FORM

Retiree Information

First Name Middle _____ Last Name

Address City State Zip

Date of Birth Social Security Number

Phone Number Email Address

Status ☐ Single ☐ Married ☐ Widowed

Union Affiliation Before Retirement ☐ DPOA ☐ DFFA ☐ DPLSA ☐ DPCOA

Retirement Date

Dependent Information

Please complete the following section for your spouse and each dependent.

First Name	Middle	Last Name	Relationship	Date of Birth	Sex	Social Security No.

Waiver of Coverage

Complete this section **only** if you choose to waive coverage. By choosing to waive coverage, you and your spouse/dependent(s) will be ineligible to enroll for one (1) year from the date you complete this form.

☐ I, _____, elect to waive coverage. I understand this election causes me, my spouse/dependent(s) to be ineligible to enroll in coverage for one (1) year from the date I complete this form.

Other Insurance Coverage

Please complete this section if you or your spouse/dependent(s) have another form of health insurance. Are you or your spouse/dependent(s) enrolled in any of the following:

☐ Health Reimbursement Arrangement	☐ You ☐ Spouse ☐ Dependent
☐ Flexible Spending Account	☐ You ☐ Spouse ☐ Dependent
☐ Health Savings Account	☐ You ☐ Spouse ☐ Dependent
☐ Medical and/or Prescription Drug Coverage	☐ You ☐ Spouse ☐ Dependent
☐ Medicare	☐ You ☐ Spouse ☐ Dependent

For each item selected above, please complete the following information (attach an additional sheet if necessary):

Insurance Company (if applicable)

Policy number (if applicable)

Is coverage employer sponsored ☐ Yes ☐ No

If yes, please provide the name of the employer

_____ _____

Signature Date

Authorization to Release HIPAA Medical Information -- This section must be completed.

I am applying to the CDPSU, which is administered through ABS and TIC, for HRA benefits. I declare: (1) all statements in this form are true to the best of my knowledge; and (2) I have not withheld or omitted any material information. I agree that ABS is not bound by any statement made by or to any agent unless written in this form. I understand any fraud or intentional misstatement about medical history or claims will result in: denial of a valid claim and loss of my HRA benefits. I certify that I have read the entire completed form.

I authorize the Authorized Disclosers to give CDPSU or its administrators; any information about me or my dependents as to: (1) diagnosis, treatment and prognosis of any physical or mental condition; (2) drug or alcohol abuse; HIV/AIDS test results, or diagnosis and/or treatment; and (3) non-medical information.
Authorized Disclosers: physicians; medical practitioners; hospitals; clinics; veterans administration facilities; other medical or medically related facilities; pharmacy benefit managers; insurers; reinsurers.

My protected health information (PHI) is: (1) individually identifiable health information, including demographic information; and (2) collected from me or created or received by a health care provider, a health plan, my employer, or a health care clearinghouse. This information must relate to: (i) my past, present, or future physical or mental health or condition; (ii) the provision of health care to me; or (iii) the past, present, or future payment for the provision of health care to me.

I can revoke this authorization at any time. I must send a written revocation to ABS at 800 Tower Drive, Suite 300, Troy, MI 48098. The revocation is effective only for future uses and disclosures of PHI. The revocation is not effective: (i) for information the CDPSU or its administrators already used or disclosed relying on this authorization; or (ii) if the authorization is a condition of eligibility for my HRA benefits.

CDPSU and its administrators ABS and TIC will not release my information except: to reinsurers or other persons or organizations performing business or legal services in connection with my application for insurance; for any claims; or as may be lawfully required; or as I may further authorize. Information that CDPSU and its administrators re-discloses for these purposes may not be protected by federal privacy laws.

I may request a copy of this authorization at any time. This authorization is valid for 30 months from the date I sign it.

Employee Signature _____ Date_____

Spouse Signature_____ Date_____
(*Required if spouse is enrolling for coverage*)

Dependent Signature_____ Date_____
(*Required if dependent age 18 or older is enrolling for coverage*)

Dependent Signature_____ Date_____
(*Required if dependent age 18 or older is enrolling for coverage*)

Dependent Signature_____ Date_____
(*Required if dependent age 18 or older is enrolling for coverage*)

Fraud Warning: Any person who, with the intent to defraud or knowingly facilitates a fraud against an insurer, submits an application or files a claim contaning a false or deceptive statement, or conceals information for the purpose of misleading may be guilty of insurance fraud and subject to criminal and/or civil penalties.