COALITION OF DETROIT PUBLIC SAFETY UNIONS TRUST
RETIREE HRA ENROLLMENT FORM

Please complete both sides of this form.

RETIREE INFORMATION

Name_____ S.S.#_____-_____-_____
Last First Middle

Home Address_____
Street City State Zip Code Country

Home (___)_____ Date of Birth_____ Date of Retirement: _____

Email Address: _____ Gender: ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Division: ☐ DPOA ☐ DPLSA ☐ DFFA ☐ DPCOA

DEPENDENT INFORMATION

First Name	Middle	Last Name	Date of Birth	Social Security Number	Gender	Relationship
					☐ M ☐ F	☐ Spouse ☐ Child
					☐ M ☐ F	☐ Spouse ☐ Child
					☐ M ☐ F	☐ Spouse ☐ Child
					☐ M ☐ F	☐ Spouse ☐ Child
					☐ M ☐ F	☐ Spouse ☐ Child

WAIVER OF COVERAGE

Complete this section only if you choose to waive coverage. By choosing to waive coverage, you and your spouse/dependent child(ren) will be ineligible to enroll in the CDPSU Trust Retiree HRA for one (1) year from the date you

☐ I, _____, elect to waive coverage. I understand this election will result in my, my spouse/dependent child(ren) to be ineligible for 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. Please indicate whether you or your spouse/dependent child(ren) are enrolled in any of the following:

☐ Health Reimbursement Arrangement	☐ You ☐ Spouse ☐ Dependent Child(ren)
☐ Flexible Spending Account (FSA)	☐ You ☐ Spouse ☐ Dependent Child(ren)
☐ Health Savings Account (HSA)	☐ You ☐ Spouse ☐ Dependent Child(ren)
☐ Medical and/or Prescription Drug Coverage	☐ You ☐ Spouse ☐ Dependent Child(ren)
☐ Medicare	☐ You ☐ Spouse ☐ Dependent Child(ren)

For each items selected above, please complete the following information:

- Insurance Company or Benefit Administrator: _____
- Policy Number (if applicable): _____
- Is the coverage employer sponsored: ☐ Yes ☐ No

If yes, please provide the name of the employer: _____

Retiree Signature _____ Date _____

AUTHORIZATION TO RELEASE HIPAA MEDICAL INFORMATION – THIS SECTION MUST BE COMPLETED

Please check each box to acknowledge and agree to the following:

☐ I am applying to the CDPSU, which is administered through Kapnick and TIC, for HRA benefits. I declare that the statements in this form are true and accurate to the best of my knowledge and I have not withheld or omitted any material information. I agree that Kapnick is not bound by any statement made by or to any of its representatives 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 dependent(s) as to: 1) diagnosis, treatment and prognosis of any physical and/or mental condition; 2) drug or alcohol abuse; HIV/AIDS test results, diagnosis, and/or treatment; and 3) non-medical information.

Authorized Disclosers include physicians, medical practitioners, hospitals, clinics, veterans administration facilities, other medical or medically related facilities, pharmacy benefit managers, insurers and 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 my past, present, or future physical or mental health or condition; the provision of health care to me; or 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 Kapnick Insurance Group at 333 Industrial Drive, Adrian, MI 49221. The revocation is effective only for future uses and disclosures of PHI following the date on which Kapnick receives it. The revocation is nor effective for information the CDPSU or its administrators already used or disclosed relying on this authorization or if the authorization is a condition of eligibility for my HRA benefits.

☐ CDPSU and its administrators Kapnick and TIC will nor release my information except to reinsurers or other persons or organization performing business or legal services in connection with my application for coverage, for any claims, as may be required by law, or as I may further authorize. Information that CDPSU and its administrators re-disclose 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.

Retiree Signature _____ Date _____

Spouse Signature _____ Date _____
(Required if spouse is enrolling for coverage)

Dependent Child Signature _____ Date _____
(Required if dependent child age 18 or older is being enrolled for coverage)

Dependent Child Signature _____ Date _____
(Required if dependent child age 18 or older is being enrolled for coverage)

Dependent Child Signature _____ Date _____
(Required if dependent child age 18 or older is being enrolled 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 containing a false or deceptive statement, or conceal information for the purpose of misleading may be guilty of insurance fraud and subject to criminal and/or civil penalties.

Please send completed enrollment forms to Kapnick using one of the following methods:

Email	Mail	Fax
hra@kapnick.com	Kapnick Insurance Group Attn: HRemote 333 Industrial Drive Adrian, MI 49221	517.264.6172

Kapnick