**The J. Paul Getty Trust**
Benefits, Human Resources
1200 Getty Center Drive, #400
Los Angeles, CA 90049-1681
310.440.6523
HR@getty.edu

# Retiree Medical Plan Enrollment Form

| **Personal Information:** | |
|---|---|
| Name: | Last 4 digits of SSN: |

**Coverage - Check (v') one of the following categories:** ☐ **Individual Only** ☐ **Individual + 1 DEPENDENT** ☐ **Individual + 2 OR MORE DEPENDENTS**

**Eligible Members –** Documentation verifying dependent eligibility is required. If additional space is needed, attach another form.

| Member | Last Name | First/M.I. | Check here to enroll individual in RRA instead of Getty Medical Plan | Date of Birth | 10-Digit PCP or Medical Group # **(HMO only)** |
|---|---|---|---|---|---|
| Individual | | | ☐ | | |
| Spouse/Domestic Partner | | | ☐ | | |
| ☐ Son ☐ Daughter | | | | | |
| ☐ Son ☐ Daughter | | | | | |

**Medical Plan Election –** these plans are only available for those listed above who are under the age of 65

☐ **Signature Value Advantage Plan – (HMO)** UnitedHealthcare - *Each family member must choose a Primary Care Physician (PCP) or Medical Group from the Signature Value Advantage Provider Directory.* Call UnitedHealthcare at 877.630.5898 to confirm your provider's participation in the network.

☐ **Signature Value Plan – (HMO)** UnitedHealthcare - *Each family member must choose a Primary Care Physician (PCP) or Medical Group from the Signature Value Provider Directory.* Call UnitedHealthcare at 877.630.5898 to confirm your provider's participation in the network.

☐ **Aetna High-Deductible Health Plan –** Call Aetna at 877.869.4077to confirm your provider's participation in the network.

☐ **Decline Medical Coverage** IMPORTANT: If you decline retiree medical, you forfeit your right to this coverage indefinitely.

Please retain a copy of this form for your records.

**The J. Paul Getty Trust**
Benefits, Human Resources
1200 Getty Center Drive, #400
Los Angeles, CA 90049-1681
310.440.6523
HR@getty.edu

# Retiree Medical Plan Enrollment Form

## Participation Terms & Conditions

**For Getty Medical Plans:**

1. By making an election, I am authorizing the J. Paul Getty Trust to deduct the required contribution for my election from my monthly Retirement Plan benefit. If I do not receive a Retirement Plan benefit, I understand that I am required to pay the required medical contribution directly to the J. Paul Getty Trust by the first day of each month. If the Getty's HR Benefits office does not receive my payment by the due date, coverage for myself and my dependents will be terminated. Required contributions are subject to change.
2. I am also authorizing HR Benefits to send necessary personal information to my selected providers to initiate and support the coverage selection I made.
3. I am attesting to the fact that my dependent is my legal spouse, registered Domestic Partner, natural child, adopted child, step child or child for whom I have legal guardianship. I understand that I may be required to provide supporting documentation of this relationship to HR Benefits. If I enroll a dependent who is not eligible, I understand that I may be liable to pay incurred claims. I agree that I will dis-enroll my dependent(s) within 31 days if they lose eligibility.
**4. I am aware that if I decline coverage for myself, I and my dependents will no longer be eligible for the Retiree Medical Plan.**
**5. I am also aware that if I decline coverage for my dependent(s), they will no longer be eligible for the Retiree Medical Plan.**
6. I understand that once I make an election, I cannot change my election until Open Enrollment, if applicable.
7. I acknowledge and accept all terms and conditions of the Getty-sponsored plans in which I have elected to enroll as stated in the Plan Document and Summary Plan Description available at www.gettybenefits.com.
8. I understand that the Getty-sponsored plans are required by law to protect the privacy of certain health information that may reveal my identity. If I specifically ask HR Benefits staff to intercede on my behalf, I am thereby consenting to the use of my protected health information by the Getty to resolve my problem. (For more information about the Getty's Privacy Policy, refer to the Summary Plan Description available at www.gettybenefits.com.)
9. I further understand that if I choose coverage under the HMO and there is any dispute between myself (or any of my covered dependents) and the HMO, the dispute will be submitted to binding arbitration in lieu of a jury or court trial.
**10. I understand that when I and/or my spouse/partner reach Medicare eligibility age (age 65), I and/or my spouse will be enrolled in a Retiree Reimbursement Account (RRA). I understand that coverage in a Getty Medical Plan will end on the date immediately preceding the effective date of the RRA.**

**For Retiree Reimbursement Accounts (RRAs):**
**1. I understand that once I and/or my spouse/partner enroll in a Retiree Reimbursement Account (RRA), I/we will not be eligible to re-join the Getty's active medical plans.**
**2. I understand that if I choose to begin receiving my RRA prior to age 65, and my spouse/partner is currently covered under my Getty active medical plan, he/she will also begin receiving an RRA with the same effective date as mine and his/her coverage in a Getty active medical plan will end on the date immediately preceding the effective date of his/her RRA.**

_____ _____

Signature Date

*(No electronic signatures accepted.)*

**For HR Benefits Use Only:** Effective Date:_____ Date Processed:_____ Processed By: _____

Please retain a copy of this form for your records.