ELECTION OF COVERAGE FOR AN ACTIVE EMPLOYEE AND COVERED SPOUSE AGE 65 AND OVER

Under the Regulations to Implement the Tax Equity & Fiscal Responsibility Act of 1982 (TEFRA), the Deficit Reduction Act of 1984 (DEFRA), and the Consolidated Omnibus Reconciliation Act of 1985 (COBRA):

Employers with 20 or more full-time and part-time employees during the previous calendar year are required to provide the following options:

The options are for any employee age 65 and over or spouse age 65 and over as long as the employee remains an active full-time employee.

1. If you elect the Employer's plan as primary coverage, Medicare will pay a secondary payor. It is the participant's responsibility to submit the bills to the Employer's plan first and to Medicare second. If bills are submitted incorrectly to Medicare, the participant may be held responsible due to incorrect filing of claims to Medicare.

2. If you elect Medicare as primary coverage, all medical benefits under the Employer's plan will cease because the employer is legally prohibited from providing inducements toward election of Medicare as primary.

Upon attainment of age 65, this form must be completed, electing the group plan as primary before any claims may be honored.

Active, full-time employees and eligible dependents are encouraged to apply for Medicare Part A & Part B upon reaching age 65.

This election is for: ☐ Employee ☐ Spouse

Name of Employee	SS#	Date of Birth

Name of Spouse	SS#	Date of Birth

1. ○ I/we wish to elect the group medical plan offered by the Employer as my primary medical coverage. I understand that Medicare is secondary medical coverage and if any bills are submitted incorrectly to Medicare I may be held responsible due to incorrect filing of these claims.

2. ○ I/we wish to elect Medicare as my primary medical coverage. I understand that coverage through my Employer's plan will cease for myself and covered dependents. If my dependents are covered by my Employer's group plan and they have no other coverage or coverage with a limitation for a pre-existing condition and under the age of 65, they would be eligible to elect COBRA for 36 months from my Medicare Entitlement (effective) Date.

Date

Signature of Employee

Signature of Spouse

Name of Group Plan

Group Policy Number

Authorized Signature of Employer

Complete and Return To:
Diversified Administration Corporation
P.O. Box 299
Marlborough, CT 06447

PDF Form DAC-EC65