

Kentucky Retirement Systems
Perimeter Park West
1260 Louisville Rd.
Frankfort KY 40601-6124
Phone: (502) 696-8800
Fax: (502) 696-8822
www.kyret.com

FORM 6200

Retired Member's
Soc. Sec. No.:

			-			-				
--	--	--	---	--	--	---	--	--	--	--

Revised 10 /2006

Retired Member's Name: _____

KENTUCKY RETIREMENT SYSTEMS MEDICARE ELIGIBLE INSURANCE ENROLLMENT FORM

APPLICANT'S NAME: _____ SOC. SEC. NO: _____

HOME ADDRESS: _____
street city state ZIP code

HOME PHONE: () _____ DATE OF BIRTH: _____ GENDER: Male Female

If you are not the retiree, what is your relationship to the retiree? Spouse Dependent Child Other (please explain) _____

Tear Along Perforation

WAIVER OF COVERAGE (Only Complete This Section If You Are Not Enrolling In A Health Plan)

I Waive Coverage* Reason for Waiving: _____

* If you waive coverage, you will not be allowed to change this election until the next open enrollment period unless your coverage terminates. If you waive coverage, complete all requested information to this point, then provide the necessary signatures on the back of this page.

MEDICARE INFORMATION (copy information exactly from the applicant's Medicare Card)

Medicare Claim Number (HIC): _____

Part A Hospital Insurance Effective Date: _____

Part B Medical Insurance Effective Date: _____

Will You Have Part D Prescription Drug Coverage In 2009: YES NO

If Yes, List The Effective Date And Carrier: _____

Do you have Medicare Coverage Due to End Stage Renal Disease _____

When Was Your Dialysis Start Date: _____

Important: Please submit a copy of the applicant's Medicare card if the applicant is a new enrollee.

PLANS AVAILABLE

- KENTUCKY RETIREMENT SYSTEMS HEALTH PLAN-MEDICAL ONLY**
- KENTUCKY RETIREMENT SYSTEMS HEALTH PLAN-PLUS
- KENTUCKY RETIREMENT SYSTEMS HEALTH PLAN- PREMIUM

***Important: If you enroll for coverage under Medicare Part D, the only KRS plan that you may elect is the Health Plan – Medical Only. If you enroll in one of the other KRS medical plans and then enroll in Medicare Part D, your KRS coverage will be changed automatically to the Health Plan – Medical Only and your premiums will be adjusted accordingly.*

Any person who knowingly and with intent to defraud any insurance company or other person files an enrollment form for insurance containing any materially false information or, for the purpose of misleading, conceals information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

I authorize release of all Medicare Part A, Part B and Part D claims information from any source for the purpose of processing my claims. This authorizes release of my Medicare claims information from the effective date of my coverage until termination of my coverage.

APPLICANT'S SIGNATURE: _____ DATE: _____

MEMBER'S SIGNATURE:
(if different from applicant): _____ DATE: _____

Return to: Kentucky Retirement Systems, Perimeter Park West, 1260 Louisville Road, Frankfort, KY 40601-6124

OFFICE USE ONLY: CHANGE/ SET UP DATE: _____ PAYROLL _____
