Senior Partner®

Medical Enrollment Form

It's Easy to Enroll.

1. Complete and sign this form.
2. Please attach a copy of your Medicare Cards (parts A & B).
3. Include check for first quarter's premium payable to the New York State Business Group.
4. Mail your completed Enrollment Form to the address below.

RETIREE INFORMATION:

Name:			**Date of Birth:**
Address:			**Social Security No.:**
City:			**Medicare No.:**
State:	**Zip:**	**Sex:**	**Phone No.:**

SPOUSE INFORMATION:

Name:	**Date of Birth:**
Social Security No.:	**Medicare No.:**

PLEASE COMPLETE THE FOLLOWING INFORMATION:

PERSONS TO BE COVERED: ☐ Retiree Only ☐ Retiree and Spouse ☐ Spouse Only

PLAN SELECTED: ☐ Option 1 (0000A) ☐ Option 2 (0001A) ☐ Standard Rx (PDP 0000) ☐ Enhanced 3-Tier Rx (ENH 3T1)

I hereby enroll in the Retiree Medical Insurance Plan issued by TRANSAMERICA Financial Life Insurance Company, Inc. (policy form LM1000GPM). I am covered by Medicare Parts A&B. I understand that this insurance is the only insurance I am enrolled in and will be effective on the first day of the month following receipt of my enrollment form.

Retiree Signature:	**Date:**
Spouse Signature:	**Date:**
	Agent Name:
	Phone:

NYSBG
New York State Business Group Inc®
Administered by: Conference Associates, Inc.

180 East Main Street, Suite 205
Patchogue, NY 11772
1-800-456-9724

Underwritten by:
TRANSAMERICA FINANCIAL LIFE INSURANCE COMPANY, PURCHASE, NY
LM1000GAM MZ0910283H 522240101