HealthTrust

Medicomp Three without Prescription Drug Coverage (MCNRX) Election Form

Retiree and/or Spouse: *(MCNRX Enrollee)* _____ **Date of Birth:** _____

Address: _____

City, State, Zip: _____

Telephone No.: _____

Former Employer: _____

Effective Date: _____

I hereby elect to enroll in the Medicomp Three without Prescription Drug Coverage (MCNRX) Plan and am indicating below my intent regarding enrolling in Medicare Part D.

____ I understand that I also must now enroll in a Medicare Part D prescription drug plan in order to be eligible for a one-time opportunity to later return to my former employer's prescription drug plan for Retirees through HealthTrust. Provided that I enroll in Medicare Part D, I will have a one-time opportunity to return to my former employer's Medicomp Three with Prescription Drug Coverage Plan through HealthTrust within 24 months of this election of the MCNRX plan, but may return only at my former employer's open enrollment or a Medicare open enrollment. If I do not return within 24 months, I understand that I will forfeit my right to return to prescription drug coverage through my former employer.

____ I do not intend to also enroll in a Medicare Part D prescription drug plan at this time. I understand that I am therefore now forfeiting all rights to later return to my former employer's Medicomp Three with Prescription Drug Coverage plan for Retirees through HealthTrust.

Retiree Signature: _____ **Date:** _____

Spouse Signature: _____ **Date:** _____

CC: Former Employer