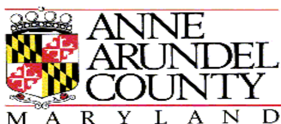

Anne Arundel County Government

Retiree Open Enrollment Health Benefits Form – 2020 Plan Year

Name: ____ SS #: __________________ Date of Birth: ___________

Address: ____ City/State/Zip: __________________________________

Gender: ______ Daytime Phone #: ______________ Email Address:____________________________________

Instructions: Use this form to make changes to your benefit elections for the 2020 calendar year. Return the completed form to the Office of Personnel, PO Box 6675, Annapolis, MD 21401 by November 30, 2019. **No response is necessary if you are not making any changes. If you do not send in a change form your current elections will be retained.**

Health Care Election- Enter coverage election(s) for 2020 calendar year

Medical Plans

- ❒ Blue Choice Triple Option Open Access
- ❒ Blue Choice HMO Open Access
- ❒ Carefirst EPO
- ❒ AETNA PPO Extended Service Area (ESA) (**Attach copy of Medicare Card**)
- ❒ No Coverage**

Medical Plan Coverage Level

- ❒ Individual
- ❒ Retiree & 1 Child
- ❒ Retiree & Spouse
- ❒ Family
- ❒ Split Option:
  - Retiree's Plan Name ______________________________
  - Retiree's Spouse Plan Name: ______________________

Dental Plans

- ❒ Cigna PPO Dental (Core)
- ❒ Cigna PPO Dental (Buy-Up)
- ❒ CIGNA Dental Care (***DHMO Network Dentist Required***)
- ❒ No Coverage**

Dental Plan Coverage Level

- ❒ Individual
- ❒ Retiree & 1 Child
- ❒ Retiree & Spouse
- ❒ Family

Vision Plan

- ❒ EyeMed Vision
- ❒ No Coverage**

Vision Plan Coverage Level

- ❒ Individual
- ❒ Retiree & 1 Child
- ❒ Retiree & Spouse
- ❒ Family

Other Health Coverage? Check here ❒ if you or your dependents are covered by another insurance policy

In the section below, list all eligible individuals for whom coverage is requested.
Attach copy of Marriage or Birth Certificate if you are adding dependents who were not covered in 2019.

Full Name	Relationship	Social Security Number	Gender	Birth Date
	SELF			

By signing below, I request enrollment as indicated above and agree to pay any premiums required to participate in the selected plans. I certify that any person for whom I am electing coverage meets the applicable requirements for spouse or dependent coverage under the Plan and I agree to inform the Benefits Office if that changes while my election of coverage is in effect. I understand that I may change my elections only during Open Enrollment, for coverage effective the next January 1, or by requesting a permitted change within 31 days of a family status change. I attest that the information provided above is complete and true to the best of my knowledge. I understand that false information will result in claim denial and possible termination of eligibility for coverage.

Retiree Signature: ____ **Date**: ________________

****Return the completed form to the Office of Personnel, PO Box 6675, Annapolis, MD 21401 by November 30, 2019.**

For Personnel Use Only: Effective Date – 1/1/2020

ADP:_______ RX:______ CIGNA:______ HCBO:______ Aet/Pru/MD:______ Entry: ______ Verify:______