ANNE ARUNDEL COUNTY GOVERNMENT

Retiree Health Benefits Change Form

NOTE: Family status changes must be reported within 31 days of the event. Please attach supporting documentation to this completed form.

RETIREE INFORMATION

Name: ______________________________ SS #: ____________________ Date of Birth: ______________

Address: ____ City/State/Zip: ____________________________

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

TYPE OF CHANGE **DATE OF CHANGE** ______________________________

- ❒ Marriage, divorce, legal separation*
- ❒ Birth, adoption, child custody (non-temporary)*
- ❒ Moving from HMO service area
- ❒ Eligible for Medicare (only option if 65 or Medicare eligible due to disability
- ❒ Employment change affecting insurance**
- ❒ Cancel dependent's coverage
- ❒ Cancel coverage
- ❒ Other ______________________

Note: *copy of legal document(s) required; **letter from employer required.

HEALTH CARE ELECTION – ENTER NEW COVERAGE

Medical Plans
- ❒ Aetna Open Choice PPO
- ❒ Open Access Aetna Select HMO-EPO
- ❒ Aetna Medicare PPO ESA (**Attach copy of the Medicare Card**)
- ❒ No Coverage

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

Dental Plans
- ❒ Cigna PPO Dental (CORE)
- ❒ Cigna PPO Dental (Buy-up)
- ❒ CIGNA DHMO
  (I understand I must use a participating DHMO network dentist. _________ (initials)
- ❒ 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

Full Name	Relationship	Social Security Number	Gender	Birth Date

Are you, your spouse or children covered by another insurance company? Yes ❒ No ❒ Coverage Type: ❒ Medical ❒ Dental
If yes: Name of Insurance Company: ______________________________ Name of Employer: ___________________________

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 understand that if I am discontinuing enrollment in any coverage under the Plan I can only re-enroll during Open Enrollment or 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**: ____________________

FOR OFFICE OF PERSONNEL USE ONLY:

COVERAGE DATE: ____________________ HEALTH ______________ RX: __________ DENTAL/VISION: __________

I2K: _______________ OBA: ____________ KEYED: ____________ VERIFIED: ______________

Rev: 8/2022 **RETURN THIS FORM TO THE OFFICE OF PERSONNEL, MS 9101, 2660 RIVA ROAD, ANNAPOLIS, MD 21401**