



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 Team 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: _____ HWSE _____ KEYED: _____ VERIFIED: _____

Rev: 8/2024 RETURN THIS FORM TO THE OFFICE OF PERSONNEL, BENEFITS TEAM, MS 9101, 2660 RIVA ROAD, ANNAPOLIS, MD 21401 OR SEND VIA EMAIL TO: benefits_team@acounty.org