ANNE ARUNDEL COUNTY GOVERNMENT

Retiree Health Benefits Change Form – 2026 Plan Year

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)*
- ❒ Eligible for Medicare (only option if 65 or Medicare eligible due to disability)

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

- ❒ Employment change affecting insurance**
- ❒ Cancel dependent's coverage
- ❒ Cancel coverage
- ❒ Other _____

HEALTH CARE ELECTION – ENTER NEW COVERAGE

Medical Plan
- ❒ BlueChoice Advantage EPO
- ❒ BlueChoice Advantage PPO
- ❒ 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 Plan
- ❒ 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 ❒ Vision
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@aacounty.org**