



# ANNE ARUNDEL COUNTY GOVERNMENT

## Retiree Health Benefits Change Form – 2027 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)

- ☐ 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 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: 7/2026 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](mailto:benefits_team@aacounty.org)