

# HOWARD COUNTY PUBLIC SCHOOLS ♦ BENEFITS CHANGE FORM

## RETIREEES (Please Print)

**1 TYPE OF REQUEST FOR STATUS CHANGE**

**The Benefits Change Form must be submitted to the Benefits Office within 30 days of status change, along with the necessary supporting documentation.**

Reason for addition:	Date of event:	Add/Remove	Date of event	Reason for termination:	Date of event:
<input type="checkbox"/> Marriage <input type="checkbox"/> Birth/Adoption of child <input type="checkbox"/> Loss of other Coverage <input type="checkbox"/> Other (explain) _____	_____ _____ _____	<input type="checkbox"/> Retiree <input type="checkbox"/> Spouse <input type="checkbox"/> Child/children <input type="checkbox"/> Other	_____ _____ _____	<input type="checkbox"/> Other Insurance <input type="checkbox"/> Divorce <input type="checkbox"/> Child reached age limit <input type="checkbox"/> Child no longer student	_____ _____ _____
<b>Update Personal Informaiton</b> <input type="checkbox"/> Update Address Below		<input type="checkbox"/> Update Name Below		<input type="checkbox"/> Other	

**2 SUBSCRIBER INFORMATION**

LAST NAME	FIRST NAME	M.I.	MAIDEN/FORMER NAME (If Applicable)	SOCIAL SECURITY NUMBER
STREET ADDRESS		CITY	STATE	ZIP
SEX <input type="checkbox"/> M <input type="checkbox"/> F	DATE OF BIRTH	HOME PHONE NUMBER	WORK PHONE NUMBER	MARITAL STATUS <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed

**3 ELECTION OF BENEFITS - Refer to the Health Benefits Enrollment Information for Details.**

<b>MEDICAL PLAN OPTIONS:</b> <i>Select a Plan</i> <input type="checkbox"/> Traditional Medical Plan* <input type="checkbox"/> Alternate Medical Plan <input type="checkbox"/> Aetna PPO <input type="checkbox"/> CareFirst BlueChoice HMO Open Access <input type="checkbox"/> Aetna Select Open Access HMO <input type="checkbox"/> Kaiser Permanente Select HMO <input type="checkbox"/> United Healthcare Choice HMO  <i>Select a Level of Coverage</i> <input type="checkbox"/> Individual <input type="checkbox"/> Parent & child (children for Aetna and Kaiser) <input type="checkbox"/> Husband & Wife <input type="checkbox"/> Family <input type="checkbox"/> I cancel/waive medical coverage	<b>INDEMNITY DENTAL PLAN OPTIONS:</b> <i>Select a Plan</i> <input type="checkbox"/> NCAS Current Dental <input type="checkbox"/> NCAS Alternate Dental <input type="checkbox"/> Delta Dental PPO  <i>Select a Level of Coverage</i> <input type="checkbox"/> Individual <input type="checkbox"/> Parent & child <input type="checkbox"/> Husband & Wife <input type="checkbox"/> Family <input type="checkbox"/> I cancel/waive dental coverage	<b>VISION PLAN</b> <i>Select a Plan</i> <input type="checkbox"/> NCAS Vision Plan <input type="checkbox"/> VSP (Vision Service Plan)  <i>Select a Level of Coverage</i> <input type="checkbox"/> Individual <input type="checkbox"/> Parent & child <input type="checkbox"/> Husband & Wife <input type="checkbox"/> Family <input type="checkbox"/> I cancel/waive vision coverage
<p><small>* Not available to employees hired on or after July 1, 1993</small></p> <p><b>Important Note: Continuation of Coverage</b>                  A retiree who cancels his/her medical, dental, and/or vision coverage(s) cannot renew that type of coverage under the Board Sponsored health options. However, as long as the retiree maintains medical, dental and/or vision coverage(s), eligible dependents may be added/removed during the annual open enrollment period.</p>		

**4 COVERED EMPLOYEE AND DEPENDENT(S) INFORMATION**

PLEASE LIST ONLY MEMBERS TO BE ADDED/REMOVED. If you are adding or removing coverage for a dependent, please check the appropriate box below and complete all of the information. If selecting Blue Choice HMO Open Access or Kaiser, indicate the primary care physician and ID#.

Last Name	First	M.I.	Relationship	<input type="checkbox"/> Add <input type="checkbox"/> Remove	Date of Birth	Social Security Number	Primary Care Physician Information (If applicable)	Existing Patient of
			Retiree				NAME: ID#	<input type="checkbox"/> Y <input type="checkbox"/> N
			Spouse				NAME: ID#	<input type="checkbox"/> Y <input type="checkbox"/> N
			Child				NAME: ID#	<input type="checkbox"/> Y <input type="checkbox"/> N
			Child				NAME: ID#	<input type="checkbox"/> Y <input type="checkbox"/> N

**DEPENDENT INFORMATION**

Disabled?     Yes  No    Name \_\_\_\_\_    Date of Disability \_\_\_\_\_

**\*\*You will be required to provide a disability statement to your insurance provider(s).**

**5 OTHER COVERAGE INFORMATION - COMPLETE BACK OF FORM**

*If you have any questions concerning the benefits and services that are provided by or excluded under the agreement, please contact the applicable plan's membership services representative before signing the application form.*

I hereby apply for myself and any dependents listed on this application for the coverage indicated and authorize my employer to deduct from my earnings the amount required to participate in the elected plans. I understand that the elections that I make on this form will remain in effect for the entire Plan Year, unless I am permitted to change them during the Plan Year under special rules contained in the plan that apply only in very limited situations. If I do not complete and file a new enrollment form during the next annual enrollment period, the elections I make on this form will continue in effect indefinitely until changed by me during an annual enrollment period or in connection with the special rules discussed above. I also understand that the elections I make on this form are subject to modification by the Employer to insure that the Plan complies with applicable laws or to reflect increases in the cost of the elected coverage(s) that occur during the Plan Year. I hereby consent, for myself and for all individuals covered by the Plan through me, to any investigations or inquiries into medical condition that are deemed necessary or appropriate by the Plan Administrator and to disclosures of medical records by anyone deemed necessary or appropriate by the Plan Administrator. I have carefully read this application and agree to its terms. The statements are true and complete and are representations made to induce the issuance of the subscription agreement(s) for which I have applied.

RETIREE'S SIGNATURE	DATE	<b>RETURN COMPLETED FORM TO:</b> Howard County Public Schools, Benefits Office 10910 Route 108, Ellicott City, MD 21042	<b>RETAIN A COPY FOR YOUR RECORDS</b>
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HOWARD COUNTY PUBLIC SCHOOLS ♦ BENEFITS CHANGE FORM  
RETIREES-CONTINUED

5 OTHER COVERAGE INFORMATION

Are you or any member of your family covered by any other group insurance, HMO plan, or Federal program including Medicare?

Medical  Yes  No Dental  Yes  No Vision  Yes  No Prescription  Yes  No

If yes, Name of Carrier: \_\_\_\_\_ Policy ID# \_\_\_\_\_

Address: \_\_\_\_\_

Effective Date: \_\_\_\_\_

Policyholder Name: \_\_\_\_\_

Are family members covered?  Yes  No If yes, which ones?  Employee  Spouse  Children

If yes, is this Plan Primary (P) or Secondary (S) for:  P  S Employee  P  S Spouse  P  S Children

**Medicare Part A**  Yes  No **Medicare Part B**  Yes  No **Medicare Part D**  Yes  No

If yes, Name of Carrier: \_\_\_\_\_ Health Insurance Claim# (HIC#): \_\_\_\_\_

Address: \_\_\_\_\_

Effective Date Part A: \_\_\_\_\_ Effective Date Part B: \_\_\_\_\_ Effective Date Part D: \_\_\_\_\_

Policyholder Name: \_\_\_\_\_

Are family members covered?  Yes  No If yes, which ones?  Employee  Spouse  Children

If yes, is this Plan Primary (P) or Secondary (S) for:  P  S Employee  P  S Spouse  P  S Children