HOWARD COUNTY PUBLIC SCHOOLS ♦ 2016 RETIREE OPEN ENROLLMENT BENEFITS CHANGE FORM

1 TYPE OF REQUEST FOR STATUS CHANGE

The Benefits Change Form must be submitted to the Benefits Office by October 30, 2015.

Add /Remove	Date of event:
☐ Retiree	
☐ Spouse	
☐ Child / Children	
☐ Opt back In	

2 SUBSCRIBER INFORMATION

LAST NAME	FIRST NAME	M.I.	MAIDEN/FORMER NAME (If Applicable)	SOCIAL SECURITY NUMBER

STREET ADDRESS	CITY	STATE	ZIP

SEX	DATE OF BIRTH	HOME PHONE NUMBER	WORK PHONE NUMBER	MARITAL STATUS
☐ M ☐ F				☐ Single ☐ Married ☐ Widowed

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

MEDICAL PLAN OPTIONS:

Select a Plan

- ☐ Aetna PPO
- ☐ Aetna Select Open Access HMO
- ☐ CareFirst BlueChoice HMO Open Access

Select a Level of Coverage

- ☐ Individual
- ☐ Parent & child (children for Aetna)
- ☐ Husband & Wife
- ☐ Family
- ☐ I cancel/waive medical coverage

INDEMNITY DENTAL PLAN OPTIONS:

Select a Plan

- ☐ Delta Dental PPO
- ☐ Cigna Dental DHMO

Select a Level of Coverage

- ☐ Individual
- ☐ Parent & children
- ☐ Husband & Wife
- ☐ Family
- ☐ I cancel/waive dental coverage

VISION PLAN

Select a Plan

- ☐ VSP (Vision Service Plan)

Select a Level of Coverage

- ☐ Individual
- ☐ Parent & children
- ☐ Husband & Wife
- ☐ Family
- ☐ I cancel/waive vision coverage

Important Notes: **Continuation of Coverage**

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.

One Time "Opt Out" Election (for retirees with a Retirement Date of 07/01/2009 and after)

A retiree who elected to "Opt Out" at the time of retirement, may re-enroll in the type of coverage(s) maintained prior to retirement, during the annual open enrollment period or in the event of a status change.

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, indicate the primary care physician and ID#.

Last Name	First	M.I.	Relationship	Sex	Date of Birth	Social Security Number	Primary Care Physician Information (If applicable)	Existing Patient of
			Retiree ☐ Add ☐ Remove				NAME: ID#	☐ Y ☐ N
			Spouse ☐ Add ☐ Remove				NAME: ID#	☐ Y ☐ N
			Child ☐ Add ☐ Remove				NAME: ID#	☐ Y ☐ 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 herby 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

RETURN COMPLETED FORM TO:
Howard County Public Schools, Benefits Office
10910 Clarksville Pike, Ellicott City, MD 21042

RETAIN A COPY FOR YOUR RECORDS

HOWARD COUNTY PUBLIC SCHOOLS ♦ BENEFITS CHANGE FORM
RETIREES-CONTINUED

OTHER COVERAGE INFORMATION

Are you covered by Medicare? ☐ Yes ☐ No

☐ Medicare Part A ☐ Medicare Part B ☐ Medicare Part D

If yes, Medicare Policy Number: _____

Effective Date: _____

Are family members covered by Medicare? ☐ Yes ☐ No If yes, which ones? ☐ Spouse ☐ Child(ren)

Medicare Part A ☐ Yes ☐ No Medicare Part B ☐ Yes ☐ No Medicare Part D ☐ Yes ☐ No

Policyholder Name: _____

Effective Date Part A:: _____ Effective Date Part B: _____ Effective Date Part D: _____

Policyholder Name: _____

Effective Date Part A:: _____ Effective Date Part B: _____ Effective Date Part D: _____

Are family member(s) covered by any other insurance? ☐ Yes ☐ No
If yes, Which ones? ☐ Spouse ☐ Child(ren)

Policy Holder Name: _____

If yes, Name of Carrier: _____ Policy Number: _____

Coverage Effective Date: _____

Policyholder Name: _____

If yes, Name of Carrier: _____ Policy Number: _____

Coverage Effective Date: _____