ANNE ARUNDEL COUNTY PUBLIC SCHOOLS

Retiree Healthcare Enrollment Application

See reverse side for instructions.

1 RETIREE INFORMATION

Last Name, First Name, MI

Home Address (no P.O. Box)

City, State, Zip Code | Email

Social Security No. (last 4 digits) **XXX-XX-** | Home Phone (Area Code + No.) | Retirement Date

2 TYPE OF ACTIVITY

☐ New applicant ☐ Open Enrollment ☐ Medicare Eligible

☐ **Lifestyle change in coverage**

(Must Complete Below – see documentation requirements on reverse)

Reason: _____

Date of event: _____ Effective date: _____ *(See #2 on reverse)*

☐ Add dependent *(See #2 on reverse)* ☐ Remove dependent *(See #2 on reverse)*

☐ Name change ☐ Address change

Healthcare Options

3 MEDICAL

☐ BlueChoice HMO "Open Access"* (***under 65***) 1901076

☐ BlueChoice HMO "Open Access"* (***over 65 or Medicare Disabled***) 1901077

☐ CareFirst BlueChoice Triple Option "Open Access"* (***under 65***) 1901080

☐ CareFirst BlueChoice Triple Option "Open Access"* (***over 65 or Medicare Disabled***) 1901081

☐ CareFirst BCBS PPN[1] out-of-area plan (***under 65***) 1901084

☐ CareFirst BCBS Medi-Comp (***over 65 or Medicare Disabled***) 1901088

☐ No Coverage ☐ No Change

Level of Coverage:

☐ Individual ☐ Retiree/Spouse ☐ Parent/Child ☐ Family

4 DENTAL

☐ CareFirst BCBS Traditional 17G2

☐ CareFirst BCBS PPO 17G2

☐ UCCI POS* 811032001

☐ No Coverage

☐ No Change

Level of Coverage:

☐ Individual ☐ Retiree/Spouse ☐ Parent/Child ☐ Family

5 VISION

☐ CareFirst BCBS Select Vision (12 mos.)

☐ No Coverage

☐ No Change

Level of Coverage:

☐ Individual ☐ Retiree/Spouse ☐ Parent/Child ☐ Family

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	Status		Last Name, First Name, MI	Sex		Date of Birth	Social Security No.	Medical	Dental	Options**		
	Add	Remove		F	M	MM / DD / YY		Dr.'s First & Last Name*	Dr.'s Name (UCCI)*	M	D	V
Retiree												
Spouse												
Child												
Child												

**** Doctor's full name is required for BlueChoice Triple Option "Open Access" (Level 1), BlueChoice HMO "Open Access", and UCCI POS.***

***** Place "x" in the coverage you have selected for each member.***

[1] *CareFirst BCBS PPN (under 65) for out of area members only.*

7 MEDICARE INFORMATION *Complete if Applicable*

Are **you** eligible for Medicare? (age 65+) ☐ Yes ☐ No

Are **you** Medicare Disabled? (under 65) ☐ Yes ☐ No

If yes, attach a copy of Medicare card

If YES, Medicare No.

Part A effective date | Part B effective date

Spouse (age 65+) ☐ Yes ☐ No

Spouse (under 65) ☐ Yes ☐ No

Child *(if Medicare disabled)* ☐ Yes ☐ No

If yes, attach a copy of Medicare card

If YES, Medicare No.

Part A effective date | Part B effective date

NOTE: CVS Caremark SilverScript will enroll you automatically in Medicare Part D coverage to participate in the AACPS Rx over 65 program. If you decline coverage, no AACPS medical coverage will be available.

8 RETIREE SIGNATURE

I certify the information in this application is true and complete. I agree to the enrollment conditions outlined on the reverse side of this application.

Signature | Date (mm/dd/yy)

Please make a copy of this form for your records.

Return original to: Anne Arundel County Public Schools, Human Resources/Retiree Benefits, 2644 Riva Road, Annapolis, MD 21401 | 410-222-5224 or 1-800-909-4882.

ENROLLMENT FORM INSTRUCTIONS

Complete ALL Sections:

Section 1 Complete the Retiree Information in full (name, social security number, home address [please provide mailing address, not vacation address], home phone, retirement date if applicable).

Section 2 Place an "X" to indicate Type of Activity associated with completing the application. A change in coverage level may only be made if it is a qualifying lifestyle change (i.e., marriage, birth, death, etc.) and the change must be made within 31 days immediately following the event. Supporting documentation should be furnished for birth (copy of birth certificate), divorce (divorce decree), or marriage license (marriage certificate). If filling out Change in Coverage, please be sure to specify the reason where noted and date event occurred. The Retirement Office will fill out effective date.

Section 3 Place an "X" to indicate both your medical plan selection (or waiver of coverage) and your level of coverage.

Section 4 Place an "X" to indicate both your dental plan selection (or waiver of coverage) and your level of coverage.

Section 5 Place an "X" to indicate both your vision plan selection (or waiver of coverage) and your level of coverage.

Section 6 Fill out the information for all eligible dependents covered. Check under "add" or "remove", fill out the name, sex, date of birth, and Social Security Number for each dependent. Complete doctor's name must be filled in for BlueChoice Triple Option "Open Access" Plan, BlueChoice HMO "Open Access", and UCCI POS (Dental). Refer to ***www.CareFirst.com***, or ***www.ucci.com***, to select the proper plan, and to look for your doctor's name and location and information. Place an **X** in the coverages (**M**edical, **D**ental, **V**ision) you have selected for each member added. Dependents are covered up to the end of the month in which they turn 26.

Section 7 If this section does not apply, please specify "**NO**". If you are covered by Medicare, please fill out the requested information—Medicare Claim Number, Parts A & B effective dates, as well as same information on spouse. ***Important: Please provide a copy of Medicare card and forward with application. Upon receipt, CVS Caremark SilverScript will automatically enroll you in Medicare Part D to participate in the AACPS over 65 retiree Rx program. If you decline this coverage, no AACPS medical coverage will be available.***

Section 8 Please sign and date where indicated on the front of this application to certify that you have completed the form in full, that all information is true, and that you agree to the conditions of enrollment. **THIS APPLICATION MUST BE FILLED OUT IN ITS ENTIRETY**.

HR/Retirement requires supporting documentation when a retiree adds a dependent (spouse or under age 26) during Open Enrollment (i.e. copy of marriage certificate or birth certificate). Please submit this with your Retiree Healthcare Enrollment Application.

CONDITIONS OF ENROLLMENT

1. Applicant requests the elections for him/herself and eligible dependents.
2. Applicant authorizes AACPS to deduct from retirement earnings the amount required to participate in elected plans.
   Note: Retirement earnings should be sufficient to cover benefit selections.
3. Applicant agrees to the terms specified in the applicable health benefits certificate or other official description for benefits elected.
4. Applicant has carefully read and agrees to the terms in this application and other enrollment information, including the definitions and eligibility provisions for dependents.
5. Applicant understands that this coverage will remain in effect until the next open enrollment period, unless a family/lifestyle status change occurs dictating a change in coverage.
6. The Group Master Contract will determine the rights and responsibilities of member(s) and will govern in the event it conflicts with any benefits comparison, summary, or other description.
7. AACPS Human Resources/Benefits complies with the Health Insurance Portability Account Act (HIPAA) of 2003. To ensure the privacy of protected healthcare information, members or covered dependents seeking healthcare claim assistance may be required to furnish written authorization directing release of such information to HR/Retirement Office staff members or from associated AACPS healthcare vendors.