



Retiree Healthcare Enrollment Application

See the Reverse Side for Instructions

Healthcare Options

1 RETIREE INFORMATION

Last Name, First Name, MI _____

Home Address (no P.O. Box) _____

City, State, Zip Code _____ Email _____

Social Security No. _____ 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

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 PPN¹ out-of-area plan (under 65) 1901084
 CareFirst BCBS Medi-Comp (over 65 or Medicare Disabled) 1901088
 No Coverage
Level of Coverage:
 Individual Retiree/Spouse
 Parent/Child Family

4 Dental

CareFirst BCBS Traditional 17G2 UCCI POS* 811032001
 CareFirst BCBS PPO 17G2 No Coverage
Level of Coverage:
 Individual Retiree/Spouse
 Parent/Child Family

5 Vision

CareFirst BCBS Select Vision (12 mos.)
 No Coverage
Level of Coverage:
 Individual Retiree/Spouse
 Parent/Child Family

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

* Doctor's full name is required for BlueChoice Triple Option "Open Access" (Level 1), BlueChoice HMO "Open Access", and UCCI POS.
Please see Section 6 information on back for further guidance.

¹ CareFirst BCBS PPN (under 65) for out of area members only.
[§] Adult Child Only

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

7 OTHER INSURANCE INFORMATION

Do you or your spouse have any other health insurance policy other than through AACPS? Yes No If YES, name of person(s) covered: _____ Date of Birth _____
 Name of Employer _____
 Insurance Company _____ Policy Number _____ Expiration Date _____

8 MEDICARE INFORMATION
Complete if Applicable

Are you eligible for Medicare? (age 65+) Yes No If yes, attach a copy of Medicare card If YES, Medicare No. _____ Part A effective date _____ Part B effective date _____ Part D **See Note Below**
 Are you Medicare Disabled? (under 65) Yes No If yes, attach a copy of Medicare card
 Spouse (age 65+) Yes No Child (if Medicare disabled) Yes No If YES, Medicare No. _____ Part A effective date _____ Part B effective date _____ Part D **See Note Below**
 Spouse (under 65) Yes No If yes, attach a copy of Medicare card

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.

9 RETIREE SIGNATURE

I certify the information in this application is true and complete. Signature _____ Date (mm/dd/yy) _____
 I agree to the enrollment conditions outlined on the reverse side of this application.

Please make a copy of this form for your records.

Return original to: Anne Arundel County Public Schools, Human Resources/Retirement Office, 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. Fill out age and handicapped status as indicated. 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** Other Insurance Information—Indicate “**NO**” if you do not have any other health coverage. If you check “**YES**”, be sure to supply who is covered, date of birth, name of employer, insurance company, and policy number as applicable.
- Section 8** 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 9** 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.