



Retiree Healthcare Enrollment Application

See page vii for instructions.

1 RETIREE INFORMATION

Last Name, First Name, MI _____
 Home Address (no P.O. Box) _____
 City, State, Zip Code _____ Email _____
 Home Phone (Area Code + No.) _____ Retirement Date _____
 Social Security No. _____

2 TYPE OF ACTIVITY

New applicant Open Enrollment Medicare Eligible
 Lifestyle change in coverage
(Must Complete Below – see documentation requirements on page vii)
 Reason: _____
 Date of event: _____ Effective date: _____ (See #2 on page vii)
 Add dependent (See #2 on page vii) Remove dependent (See #2 on page vii)
 Name change Address change

Healthcare Options

3 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

Level of Coverage:
 Individual Retiree/Spouse
 Parent/Child Family

4 CareFirst BCBS Traditional 17G2 UCCI POS* 811032001
 CareFirst BCBS PPO 17G2 No Coverage

Level of Coverage:
 Individual Retiree/Spouse
 Parent/Child Family

5 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	Social Security No.	Medical	Dental	Options ^{**}	
	Add	Remove									Dr's First & Last Name*	Dr's Name (UCCI)*
Retiree				F		Y	/ /	-				
Spouse				M		N	/ /	-				
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.
 ** 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**
 Are you Medicare Disabled? (under 65) Yes No
 Spouse (age 65+) Yes No **Child (if Medicare disabled)** Yes No
 Spouse (under 65) Yes No **If yes, attach a copy of Medicare card**

Part A effective date _____ Part B effective date _____ Part D **See Note Below**
 Part A effective date _____ Part B effective date _____ Part D **See Note Below**

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.
 I agree to the enrollment conditions outlined on the reverse side of this application.
 Signature _____ Date (mm/dd/yy) _____