ANNE ARUNDEL COUNTY PUBLIC SCHOOLS

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

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 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 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

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	Social Security No.	Medical	Dental	Options**		
	Add	Remove		F	M		Y	N	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. Please see Section 6 information on back for further guidance.***

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

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

▲ *Adult Child Only*

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 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 | Part D *See Note Below*

Spouse (age 65+) ☐ Yes ☐ No Child *(if Medicare disabled)* ☐ Yes ☐ No Spouse (under 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*

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)

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.