20__
Medicare-Eligible Retiree Enrollment & Change Form

OHR use only
Effective date: _____
Processed Date: _____
OHR Rep: _____

RETIREE NAME: _____

ADDRESS: _____

MEDICAL PLAN SECTION

ENROLLMENT ACTION:
[ ] enroll [ ] change plan [ ] add spouse/dependents [ ] delete spouse/dependents [ ] waive or cancel plan

Opt Out:
[ ] I elect to opt out of the retiree health insurance at this time. (**You must notify HR to re-enroll at later date. Can enroll only at a future open enrollment period or due to qualifying status change). Indicate premium tier here: _____**

MEDICAL PLAN SELECTION:	**MEDICAL PLAN COVERAGE LEVEL:**	**COST (from rate sheet):**
[ ] Kaiser HMO Medicare Cost Plus	[ ] You	$_____
[ ] Aetna Medicare Advantage 95 Plan	[ ] You & Spouse	$_____
[ ] Aetna Medicare Advantage 10 Plan		

MEDICARE ENROLLMENT INFORMATION: – provide your Medicare enrollment information for you and/or your spouse below. Please include a copy of your Medicare ID card along with this enrollment form.

Your Medicare ID #: _____ Spouse Medicare ID#: _____

Your Part A effective date: _____ Spouse Part A effective date: _____

Your Part B effective date: _____ Spouse Part B effective date: _____

END STAGE RENAL DISEASE: – Indicate below if you and/or your spouse are in End Stage Renal Disease
Are you in end stage renal disease? Yes _____ No _____
Is your spouse in end stage renal disease? Yes _____ No _____

DENTAL PLAN SECTION

ENROLLMENT ACTION:
[ ] enroll [ ] change plan [ ] add spouse/dependents [ ] delete spouse/dependents [ ] waive or cancel plan

DENTAL PLAN SELECTION:	**DENTAL PLAN COVERAGE LEVEL:**	**COST (from rate sheet):**
[ ] Delta Dental PPO Plus	[ ] You	$_____
[ ] Dominion EPO	[ ] You & Spouse	$_____

RETIREE & DEPENDENT ENROLLMENT INFORMATION:

	Name	**Sex**	**SS#**	**Birth date**	**Medical**	**Dental**
Retiree:					[ ]	[ ]
Spouse:					[ ]	[ ]

IF ENROLLING IN KAISER HMO, YOU MUST DESIGNATE A KAISER PRIMARY CARE PHYSICIAN (PCP):

Employee: _____ PCP name & number: _____
Spouse: _____ PCP name & number: _____

RETIREE ACKNOWLEDGEMENT & SIGNATURE:
I agree that care providers may furnish information to the insurers I have selected above concerning medical diagnosis, treatments, or services in connection with any condition for which I or my dependents seek care under a Howard County Government benefit plan. I understand that if I elected the one-time opt out feature, I may only re-enroll at a future open enrollment period or due to a qualifying status change. I understand that I may not make a benefit election change except in the event of a status change as permitted under IRS regulations. I understand that if a status change occurs I must notify Human Resources **no later than 30 days** from the date of the status change, or I will not be permitted to make a benefit change until the next annual open enrollment period.

RETIREE SIGNATURE: _____ **DATE:** _____

PHONE NUMBER: _____ **EMAIL ADDRESS:** _____