County Flex Benefits
20__
Retiree
Enrollment & Change Form

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

RETIREE NAME: _____

ADDRESS: _____

MEDICAL PLAN 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	[ ] You	$_____
[ ] Aetna PPO	[ ] You & Spouse	$_____
[ ] Aetna Select Open Access	[ ] You & Children	$_____
	[ ] Family	$_____

DENTAL PLAN 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 Dental EPO	[ ] You & Spouse	$_____
	[ ] You & Children	$_____
	[ ] Family	$_____

RETIREE & DEPENDENT ENROLLMENT INFORMATION:

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

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

Employee: _____ PCP name & number: _____

Spouse: _____ PCP name & number: _____

Child: _____ PCP name & number: _____

Child: _____ 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: _____

E-MAIL ADDRESS: _____