

**STATE OF DELAWARE OFFICE OF PENSIONS  
APPLICATION FOR HEALTH CARE COVERAGE**

Revised March 2014

**A. REASON FOR APPLICATION**

- New coverage
- Change coverage
- Information change
- Medicare Eligible
- Refuse coverage (see Section F)

**ADD DEPENDENTS DUE TO:**

- Date of event checked: \_\_\_\_\_
- Marriage/Civil Union
  - Non-voluntary coverage loss
  - Birth       Other
  - Adoption/Guardianship

**CANCEL DEPENDENTS DUE TO:**

- Date of event checked: \_\_\_\_\_
- Divorce
  - Over age
  - No longer dependent
  - Death
  - Other

**REINSTATE COVERAGE DUE TO:**

- Date of event checked: \_\_\_\_\_
- Administrative error
  - Other

**B. PERSONAL INFORMATION**

<input type="checkbox"/> Male	<input type="checkbox"/> Retiree	<input type="checkbox"/> Non-employee	Date of Retirement (month, day, year)		Social Security Number		Agency or School District		
<input type="checkbox"/> Female	<input type="checkbox"/> Surviving spouse						<b>PENSION OFFICE</b>		
Last Name			First Name		M.I.	Date of Birth (month, day, year)		Home Phone (include area code)	
Street Address							City	State	Zip Code
Business Phone (include area code)									

**C. HEALTH CARE COVERAGE CHOICES**

**COVERAGE IS FOR:**  Individual     Individual & Spouse     Individual & child (ren)     Family

*\*Relationship of Spouse applies to Spouse or Civil Union Spouse*

*\*Relationship of Dependent applies to Dependent(s) and/or Civil Union Dependent(s)*

**PLEASE MAKE ONE HEALTHCARE COVERAGE CHOICE:**

- Highmark First State Basic     Highmark IPA/HMO     Aetna HMO     Highmark Comp PPO
- Highmark Consumer Directed Health Gold     Aetna Consumer Directed Health Gold

**OR**

**MEDICARE SUPPLEMENT COVERAGE CHOICE:**

- Highmark Special Medicfill with prescription     Highmark Special Medicfill without prescription

**MEDICARE INFORMATION: Must enroll if eligible**

**Please include copy of Medicare card with this application.**

Applicant's Medicare #: \_\_\_\_\_

Part A Effective Date: \_\_\_\_\_

Part B Effective Date: \_\_\_\_\_

**D. ELIGIBLE DEPENDENTS TO BE COVERED / PRIMARY CARE PHYSICIAN SELECTION**

**\*If you choose Highmark DE IPA/HMO or Aetna HMO coverage, you MUST select a primary care physician (PCP) for yourself, spouse and all eligible dependents  
If more space is needed to list dependents, please use a separate sheet of paper and attach it to this application.**

Name of Your Primary Care Physician				Physician's ID Number		Is this your current physician? <input type="checkbox"/> YES <input type="checkbox"/> NO					
<input type="checkbox"/> Add <input type="checkbox"/> Cancel	Spouse's First Name		M.I.	Last Name (if different), Jr., Sr.		Birth Date / /	Spouse's Social Security Number		Spouse's Primary Care Physician	Physician's ID Number	Spouse's current physician? <input type="checkbox"/> Y <input type="checkbox"/> N
<input type="checkbox"/> Add <input type="checkbox"/> Cancel	Dependent's First Name <input type="checkbox"/> Fulltime student <input type="checkbox"/> Male <input type="checkbox"/> Handicapped <input type="checkbox"/> Female		M.I.	Last Name (if different), Jr., Sr.		Birth Date / /	Dependent's Social Security Number		Dependent's Primary Care Physician	Physician's ID Number	Dependent's current physician? <input type="checkbox"/> Y <input type="checkbox"/> N
<input type="checkbox"/> Add <input type="checkbox"/> Cancel	Dependent's First Name <input type="checkbox"/> Fulltime student <input type="checkbox"/> Male <input type="checkbox"/> Handicapped <input type="checkbox"/> Female		M.I.	Last Name (if different), Jr., Sr.		Birth Date / /	Dependent's Social Security Number		Dependent's Primary Care Physician	Physician's ID Number	Dependent's current physician? <input type="checkbox"/> Y <input type="checkbox"/> N
<input type="checkbox"/> Add <input type="checkbox"/> Cancel	Dependent's First Name <input type="checkbox"/> Fulltime student <input type="checkbox"/> Male <input type="checkbox"/> Handicapped <input type="checkbox"/> Female		M.I.	Last Name (if different), Jr., Sr.		Birth Date / /	Dependent's Social Security Number		Dependent's Primary Care Physician	Physician's ID Number	Dependent's current physician? <input type="checkbox"/> Y <input type="checkbox"/> N

**E. OTHER COVERAGE INFORMATION**

Anyone covered by other health insurance? <input type="checkbox"/> I am <input type="checkbox"/> My spouse <input type="checkbox"/> My dependent child(ren)		If YES, and the coverage is through an employer, list name of employer below:		Name and Location of Other Insurance Company		Transferring your coverage from another Blue Cross Blue Shield contract? <input type="checkbox"/> Y <input type="checkbox"/> N	
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**F. TERMS OF AGREEMENT**

I understand that: 1) Rights to service are subject to acceptance of this application and to the terms and conditions specified in the present contract and any future contract between my employer, association and Highmark Delaware or Aetna. 2) I certify that all representations and information supplied by me are true. My coverage shall be void if any or part of this application is false or incomplete. 3) I authorize my employer, as my agent, if applicable to collect the premiums by payroll deduction or otherwise, for remittance to Highmark Delaware or Aetna, with the understanding that payment will not be complete until actually received. 4) I, on behalf of myself and my covered dependents, authorize any physician, hospital or any other health care provider to release information available to them concerning any diagnosis

treatment or other health care services they render to me or my covered dependents its designee for purposes reasonably related to this contract. 5) I, on behalf of myself and my covered dependents, authorize Highmark Delaware or Aetna to release appropriate demographic information, diagnostic and medical conditions to other persons, entities or organizations for audits, claims processing, coordination of benefits, disease management programs, member satisfaction surveys, other party liability, utilization review, case management, quality improvement and assurance and other reasonably related purposes for the administration of this contract or as required by law.

I **ELECT** to participate in the State Health Insurance and do agree to the above terms.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

I elect **NOT** to participate in the State Health Insurance.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# State Of Delaware Office Of Pensions Dental Application



### Effective Date

M	M	D	D	Y	Y	Y	Y

Please check the applicable box or boxes.

<input type="checkbox"/> New enrollment	<input type="checkbox"/> Name Change	<input type="checkbox"/> Change of dependents
<input type="checkbox"/> Coverage Change	<input type="checkbox"/> Address Change	<input type="checkbox"/> Termination

Please select who coverage is for: Please select one dental plan of your choice:

<input type="checkbox"/> Employee	<input type="checkbox"/> Delta Dental #1260-0001
<input type="checkbox"/> Employee & Spouse	<input type="checkbox"/> Dominion Dental #15339- <i>*Must provide Dentist</i>
<input type="checkbox"/> Employee & Child(ren)	
<input type="checkbox"/> Family	

**NOTE: INCOMPLETE INFORMATION ON THIS FORM WILL DELAY YOUR ENROLLMENT. PLEASE PRINT CLEARLY.**

Social Security Number	Employee Name (Last ,First, Middle Initial)	Date of Birth
Home Address		Home Phone
City	State	Zip Code
		Work Phone
Date of Marriage	Marital Status Single   Married/Civil Union   Widowed   Divorced   Separated	
Agency <b>PENSION OFFICE</b>	*Relationship of Spouse applies to Spouse or Civil Union Spouse *Relationship of Dependent applies to Dependent(s) and/or Civil Union Dependent(s)	

**PLEASE LIST HERE ALL FAMILY MEMBERS TO BE COVERED BY THIS ENROLLMENT**

Last Name	First Name	MI	Sex	Date of Birth	Social Security	*Primary Care Dentist Name	*Primary Care Dentist Code
Self							
Spouse							
Child <input type="checkbox"/> fulltime student <input type="checkbox"/> handicapped							
Child <input type="checkbox"/> fulltime student <input type="checkbox"/> handicapped							
Child <input type="checkbox"/> fulltime student <input type="checkbox"/> handicapped							

**IMPORTANT :** Do you or your dependent(s) have other Group Dental Coverage?    YES    NO  
If your answer to the above question is yes, please complete the following information.

Name of Insured	Insurance Company	Policy Number
Name of Insured	Insurance Company	Policy Number
Name of Insured	Insurance Company	Policy Number

Employee's Signature \_\_\_\_\_ Date \_\_\_\_\_



# Enrollment/Change Form

Please print and complete all sections.

See instructions below.

Underwritten by Fidelity Security Life Insurance Company of  
Kansas City, Missouri

## EMPLOYER INFORMATION: To be Completed by Employer

<b>Group Number</b>	<b>Employer Name</b>	<b>Effective Date</b>
9812363	State of Delaware	

## PENSIONER INFORMATION A: Add (enroll) T: Terminate C: Change (change of name, address or phone)

<input type="checkbox"/> ADD <input type="checkbox"/> TERM <input type="checkbox"/> CHG	<b>Gender</b> <input type="checkbox"/> M <input type="checkbox"/> F	<b>Pensioner ID</b>	<b>Last Name (Pensioner or subscriber)</b>	<b>First Name</b>	<b>M.I.</b>	<b>Date of Birth</b>
<b>Social Security Number</b>	<b>Home Street Address</b>		<b>City/State/Zip</b>		<b>Home Phone ( )</b>	

## FAMILY INFORMATION (Only those eligible may be enrolled.) A: Add (enroll) T: Terminate C: Change (change of name)

<input type="checkbox"/> A <input type="checkbox"/> T <input type="checkbox"/> C	<b>Gender</b> <input type="checkbox"/> M <input type="checkbox"/> F	<b>Last Name (pensioner)</b>	<b>First Name</b>	<b>M.I.</b>	<b>Date of Birth</b>
<input type="checkbox"/> A <input type="checkbox"/> T <input type="checkbox"/> C	<b>Gender</b> <input type="checkbox"/> M <input type="checkbox"/> F	<b>Last Name (spouse)</b>	<b>First Name</b>	<b>M.I.</b>	<b>Date of Birth</b>
<input type="checkbox"/> A <input type="checkbox"/> T <input type="checkbox"/> C	<b>Gender</b> <input type="checkbox"/> M <input type="checkbox"/> F	<b>Last Name (dependent)</b>	<b>First Name</b>	<b>M.I.</b>	<b>Date of Birth</b>
<input type="checkbox"/> A <input type="checkbox"/> T <input type="checkbox"/> C	<b>Gender</b> <input type="checkbox"/> M <input type="checkbox"/> F	<b>Last Name (dependent)</b>	<b>First Name</b>	<b>M.I.</b>	<b>Date of Birth</b>
<input type="checkbox"/> A <input type="checkbox"/> T <input type="checkbox"/> C	<b>Gender</b> <input type="checkbox"/> M <input type="checkbox"/> F	<b>Last Name (dependent)</b>	<b>First Name</b>	<b>M.I.</b>	<b>Date of Birth</b>

<b>Pensioner Signature:</b> _____	<b>Date:</b> _____
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### Instructions:

**Effective date:** Beginning date of coverage.

**Family Information:** List only eligible family members who are enrolling.

Dependent eligibility is the same as employer's health plan.

**(A) Add:** Open (group) enrollment or new (individual) enrollment during the contract period.

**(T) Terminate:** To terminate enrollment.

**(C) Change:** A change of Pensioner name, address or phone

The vision plan is a binding election. Once enrolled, you may not drop coverage during the plan year.

Please note: The enrollment form is for the Pension Office's use only and will not be used for any external purpose.



**OFFICE OF PENSIONS**

**VISION INSURANCE COVERAGE**

**REFUSAL**

I have been advised of the vision plan provided by EyeMed Vision Care.

I elect not to participate in the vision insurance coverage plan offered through the Office of Pensions.

Name: \_\_\_\_\_

Employee ID: \_\_\_\_\_

Signature: \_\_\_\_\_

Social Security # \_\_\_\_\_

Date: \_\_\_\_\_

In most cases, future enrollment opportunities in the plans are restricted to an annual reopening.





**OFFICE OF PENSIONS**  
**DENTAL INSURANCE COVERAGE**

**REFUSAL**

I elect not to participate in a dental insurance coverage plan offered through the Office of Pensions.

Name: \_\_\_\_\_

Employee ID: \_\_\_\_\_

Signature: \_\_\_\_\_

Social Security # \_\_\_\_\_

Date: \_\_\_\_\_

In most cases, future enrollment opportunities in the plans are restricted to an annual reopening.



# OFFICE OF PENSIONS

## HEALTH INSURANCE COVERAGE

**REFUSAL**

I elect not to participate in a health insurance coverage plan offered through the Office of Pensions.

Name: \_\_\_\_\_

Employee ID: \_\_\_\_\_

Signature: \_\_\_\_\_

Social Security # \_\_\_\_\_

Date: \_\_\_\_\_

In most cases, future enrollment opportunities in the plans are restricted to an annual reopening.

Form DR (4/2007) §