NON-MEDICARE

STATE OF DELAWARE OFFICE OF PENSIONS
APPLICATION FOR *NON-MEDICARE* HEALTH CARE COVERAGE

Revised March 2015

A. REASON FOR APPLICATION

Date of Event Checked: 07/01/2016

☐ New coverage
☐ Change coverage
☐ Information change
☐ Refuse coverage *(see Section F)*

ADD DEPENDENTS DUE TO:

☐ Marriage/Civil Union
☐ Non-voluntary coverage loss
☐ Birth ☐ Adoption / Guardianship
☐ Other____________________

CANCEL DEPENDENTS DUE TO:

☐ Divorce ☐ Death
☐ Over age ☐ Other
☐ No longer dependent

B. PERSONAL

☐ Male ☐ Female ☐ Retiree ☐ Surviving spouse ☐ Non-employee	Date of Retirement (month / day / year)	Social Security Number	Agency **PENSION OFFICE**

Last Name	First Name	M.I.	Date of Birth (month, day, year)	Home Phone (include area code)	Business Phone (include area code)

Street Address	City	State	Zip 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 Child/Dependent applies to Child/Dependent(s) and/or Civil Union Child/Dependent(s)*

PLEASE MAKE ONE HEALTHCARE COVERAGE CHOICE:

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

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? ☐YES ☐NO

☐Add ☐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? ☐Y ☐N
☐Add ☐Cancel	Dependent's First Name ☐ Fulltime student ☐Male ☐ Handicapped ☐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? ☐Y ☐N
☐Add ☐Cancel	Dependent's First Name ☐ Fulltime student ☐Male ☐ Handicapped ☐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? ☐Y ☐N
☐Add ☐Cancel	Dependent's First Name ☐ Fulltime student ☐Male ☐ Handicapped ☐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? ☐Y ☐N

E. OTHER COVERAGE INFORMATION

Anyone covered by other health insurance? ☐I am ☐My spouse ☐ 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? ☐Y ☐N

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:________________