

A. REASON FOR APPLICATION

Effective Date:

***ADD DEPENDENTS DUE TO:**

***CANCEL DEPENDENTS DUE TO:**

****Note: Qualifying Event Documentation Is Required***

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

- Marriage/Civil Union
- Non-voluntary coverage loss
- Birth Other _____
- Adoption / Guardianship

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

B. PERSONAL

<input type="checkbox"/> Male	<input type="checkbox"/> Retiree	<input type="checkbox"/> Survivor Pensioner	Pension Employee ID OR Social Security Number	Agency
<input type="checkbox"/> Female	<input type="checkbox"/> Spouse	<input type="checkbox"/> Dependent	PENSION OFFICE	
Last Name		First Name		M.I.
		Date of Birth (month / day / year)		Primary Phone # (XXX-XXX-XXX)
Street Address		City		State Zip Code

C. HEALTH CARE COVERAGE CHOICES

COVERAGE IS FOR:

- Individual
- Individual & Spouse
- Individual & Child(ren)
- Family

Are you eligible for Double State Share? No Yes

PLEASE MAKE ONE HEALTHCARE COVERAGE CHOICE:

- Highmark Delaware First State Basic Plan
- Highmark Delaware Comprehensive PPO Plan
- Aetna HMO Plan
- Aetna Consumer Directed Health (CDH) Gold Plan

Spousal Coordination of Benefits (SCOB): If you have selected Individual & Spouse or Family Coverage, you **MUST** complete the SCOB Form upon initial enrollment, anytime enrollment or insurance status changes and each year during Open Enrollment. The SCOB Policy and electronic form can be found at: <https://dhr.delaware.gov/benefits/cob/pensioners.shtml>.

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

***If you choose Aetna HMO coverage, you MUST include an Aetna in-network primary care physician (PCP) for yourself, spouse and all eligible dependents. If more space is needed to list dependents, please use a separate form 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	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"/> Fulltime student <input type="checkbox"/> Male <input type="checkbox"/> Disabled <input type="checkbox"/> Female									
<input type="checkbox"/> Add <input type="checkbox"/> Cancel	Dependent's First Name	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"/> Fulltime student <input type="checkbox"/> Male <input type="checkbox"/> Disabled <input type="checkbox"/> Female									
<input type="checkbox"/> Add <input type="checkbox"/> Cancel	Dependent's First Name	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"/> Fulltime student <input type="checkbox"/> Male <input type="checkbox"/> Disabled <input type="checkbox"/> Female									

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: _____