

**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	<b>PENSION OFFICE</b>	
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: \_\_\_\_\_

**STATE OF DELAWARE OFFICE OF PENSIONS**

**APPLICATION FOR HEALTH CARE COVERAGE - SPECIAL MEDICFILL (Medicare Supplement)**

Revised April 2018

**A. REASON FOR APPLICATION**

New coverage                       Change coverage                      Effective Date of Coverage \_\_\_\_\_  
 Information change                       Double State Share Eligible

**B. PERSONAL INFORMATION**

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

**C. HEALTH CARE COVERAGE CHOICES**

**MEDICARE SUPPLEMENT COVERAGE CHOICE:**

**MEDICARE INFORMATION: Must enroll if eligible  
Please include copy of signed Medicare card with this application.**

Highmark Special Medicfill with prescription                      Applicant's Medicare #: \_\_\_\_\_  
 Highmark Special Medicfill **without** prescription                      Part A Effective Date: \_\_\_\_\_ Part B Effective Date: \_\_\_\_\_

**E. OTHER COVERAGE INFORMATION**

Are you covered by other health insurance? <input type="checkbox"/> Y <input type="checkbox"/> N	If YES, is this coverage an Advantage Plan? <input type="checkbox"/> Y <input type="checkbox"/> N	Are you covered by another Part D qualified prescription plan? <input type="checkbox"/> Y <input type="checkbox"/> N	Name of Other Insurance Company:
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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. 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 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 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: \_\_\_\_\_

**RETURN THIS FORM TO:** Office of Pensions, McArdle Bldg, 860 Silver Lake Blvd, Ste 1, Dover, DE 19904-2402



# 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 the coverage is for:

Please select one dental plan of your choice:

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

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

Pension Employee ID or Social Security Number	Pensioner Name (Last, First Middle Initial)	Date of Birth
Home Address		Home Phone
City	State	Zip Code
Date of Marriage	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married/Civil Union <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> 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 <span style="font-size: small;">fulltime student <input type="checkbox"/></span> <span style="font-size: small;">disabled <input type="checkbox"/></span>							
Child <span style="font-size: small;">fulltime student <input type="checkbox"/></span> <span style="font-size: small;">disabled <input type="checkbox"/></span>							
Child <span style="font-size: small;">fulltime student <input type="checkbox"/></span> <span style="font-size: small;">disabled <input type="checkbox"/></span>							

**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

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



# Vision Enrollment/Change Form

Please print and complete all sections.  
See instructions below.

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

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 the coverage is for:

- |  |                            |
|--|----------------------------|
| <input type="checkbox"/> Individual              | Effective Date:            |
| <input type="checkbox"/> Individual & Spouse     | Group Number: 1005413      |
| <input type="checkbox"/> Individual & Child(ren) | Agency: Office of Pensions |
| <input type="checkbox"/> Family                  |                            |

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

Pension Employee ID or Social Security Number	Pensioner Name(Last, First Middle Initial)	Date of Birth
Home Address		Home Phone
City	State	Zip Code
		Work Phone

Marital Status

- Single    Married/Civil Union    Widowed    Divorced    Separated

\*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	Gender	Date of Birth	Social Security
Self					
Spouse					
Child	fulltime student <input type="checkbox"/> disabled <input type="checkbox"/>				
Child	fulltime student <input type="checkbox"/> disabled <input type="checkbox"/>				
Child	fulltime student <input type="checkbox"/> disabled <input type="checkbox"/>				

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

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

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.

Form VR (2/2011) §



# 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) §