MEDICARE ELIGIBLE

RESET FORM

STATE OF DELAWARE OFFICE OF PENSIONS
APPLICATION FOR HEALTH CARE COVERAGE
HIGHMARK BLUE CROSS BLUE SHIELD DE FREEDOM BLUE PPO MEDICARE ADVANTAGE PLAN

A. PERSONAL:

☐ Male ☐ Female	☐ Retiree ☐ Spouse ☐ Dependent	Pension ID OR SSN:	Agency: **OFFICE OF PENSIONS**	
Last Name:	First Name:	Date of Birth:	Phone Number:	Alternate Phone Number:
Address:		City:	State:	Zip Code:

B. REASON FOR APPLICATION:

Effective Date: _____

☐ New coverage
☐ Change coverage

I want to voluntarily terminate my coverage effective _____ due to:

☐ Return to Work
☐ Other Coverage
☐ Other _____

** If refusing or terminating coverage, please complete Section A & B and sign refusal at the bottom right of page ONLY.*

C. HEALTH CARE COVERAGE CHOICES:

MEDICARE ADVANTAGE COVERAGE CHOICE:

☐ Highmark DE Freedom Blue PPO with prescription

Are you eligible for Double State Share? Y ☐ N ☐

MEDICARE INFORMATION: Must enroll if eligible

Please include copy of Medicare card with this application.

Medicare #: _____

Part A Effective Date: _____ Part B Effective Date: _____

D. OTHER COVERAGE INFORMATION:

Are you covered by other health insurance?	If YES, is this coverage	Are you covered by another Part D qualified prescription plan?	Name of Other Insurance Company:
☐ Y ☐ N	☐ Medicare Supplement /Medigap ☐ Medicare Advantage	☐ Y ☐ N	

E. 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 agree to the above terms. This is a **binding election**.

X_____ _____

SIGNATURE **DATE**

I **REFUSE** to participate in the State Health Insurance.

X_____ _____

SIGNATURE **DATE**

RETURN THIS FORM TO: Office of Pensions, 860 Silver Lake Blvd., Suite 1, Dover, DE 19904 or FAX 302-739-6129 **EMAIL:** PENSIONOFFICE@DELAWARE.GOV