NON-MEDICARE

RESET FORM

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

If refusing coverage, please complete Section A and sign the refusal at the bottom of page ONLY.

A.PERSONAL:

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

B. REASON FOR APPLICATION:

Effective Date: _____

☐ New coverage
☐ Change coverage

***ADD DEPENDENTS DUE TO:**
****Note: Qualifying Event Documentation Is Required***
☐ Marriage ☐ Adoption / Guardianship
☐ Non-voluntary coverage loss ☐ Other ☐ Birth

***CANCEL DEPENDENTS DUE TO:**
☐ Divorce ☐ Over age ☐ No longer dependent
☐ Death ☐ Other

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 ☐ Aetna HMO Plan
☐ Highmark Delaware Comprehensive PPO Plan ☐ Aetna Consumer Directed Health 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://www.delawarepensions.com.

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			
☐ Add ☐ Cancel	Spouse's Last Name		First Name	Birth Date	Spouse's SSN	Spouse's Primary Care Physician	Physician's ID Number
☐ Add ☐ Cancel	☐ Fulltime student ☐ Disabled	☐ Male ☐ Female	Dependent's Last Name	First Name.	Birth Date	Dependent's SSN	Dependent's Primary Care Physician	Physician's ID Number
☐ Add ☐ Cancel	☐ Fulltime student ☐ Disabled	☐ Male ☐ Female	Dependent's Last Name	First Name	Birth Date	Dependent's SSN	Dependent's Primary Care Physician	Physician's ID Number
☐ Add ☐ Cancel	☐ Fulltime student ☐ Disabled	☐ Male ☐ Female	Dependent's Last Name	First Name	Birth Date	Dependent's SSN	Dependent's Primary Care Physician	Physician's ID Number

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

X_____ X_____
SIGNATURE **DATE**

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

X_____ X_____
SIGNATURE **DATE**

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