***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.

RESET FORM

## STATE OF DELAWARE OFFICE OF PENSIONS

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

**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:**

☐ New coverage
☐ Change coverage
☐ Information change
☐ Termination/Refusal of coverage for spouse and/or dependents
***You must complete section A and sign below.**
☐ Double State Share Eligible

Effective Date of Coverage: _____

**C. HEALTH CARE COVERAGE CHOICES:**

**MEDICARE SUPPLEMENT COVERAGE CHOICE:**

☐ Highmark Special Medicfill with prescription

☐ Highmark Special Medicfill **without** prescription

**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 an Advantage Plan? | Are you covered by another Part D qualified prescription plan? | Name of Other Insurance Company: |
|---|---|---|---|
| ☐ Y ☐ N | ☐ Y ☐ N | ☐ 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_____ 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

RESET FORM

# STATE OF DELAWARE
# OFFICE OF PENSIONS

## MEDICARE SUPPLEMENT WAIVER/TERMINATION

**PLEASE COMPLETE AND RETURN FORM TO THE OFFICE OF PENSIONS**

NAME:_____ PENSION ID OR SSN:_____

PENSION PLAN: (Check One)
☐ State Employees' ☐ New State Police ☐ County/Municipal Police
☐ Closed State Police ☐ County/Municipal General

TELEPHONE NUMBER: _____

I have been advised of my eligibility to enroll in the Medicare supplemental plan provided by Highmark Delaware that requires that I enroll in Medicare Parts A and B when eligible. I elect **not** to participate in this supplemental plan offered through the Office of Pensions. If enrolled in a healthcare insurance plan through the State of Delaware, my coverage **will terminate** upon becoming Medicare eligible. In waiving this coverage, I understand that I may not enroll until the next Open Enrollment period unless I experience an involuntary loss of coverage. I also understand that if I have a loss of coverage, I have 30 days to notify the Office of Pensions.

**By signing this waiver, I understand my medical and prescription coverage will be terminated.**

X_____ X_____

**SIGNATURE** **DATE**

860 SILVER LAKE BLVD., SUITE 1 · MCARDLE BUILDING · DOVER, DE 19904 / SLC D570A
PHONE: (302) 739-4208 · TOLL FREE: (800) 722-7300 · FAX: (302) 739-6129 · EMAIL: PENSIONOFFICE@DELAWARE.GOV
WWW.DELAWAREPENSIONS.COM

RESET FORM

# STATE OF DELAWARE
# OFFICE OF PENSIONS

# DENTAL APPLICATION OR REFUSAL

**PLEASE COMPLETE AND RETURN FORM TO THE OFFICE OF PENSIONS**

**Effective Date: _____**

**A. PLEASE CHECK THE APPLICABLE BOX OR BOXES:**

| | | |
|---|---|---|
| ☐ New Enrollment | ☐ Termination/Refusal | ☐ Change of Dependents |
| ☐ Coverage Change | ☐ Address Change | ☐ Name Change |

**B. PLEASE SELECT COVERAGE OPTION:**

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

**C. PLEASE SELECT ONE DENTAL PLAN:**

☐ Delta Dental

☐ Dominion National ***Must provide Dentist Name**

**D. PLEASE COMPLETE ALL PERSONAL INFORMATION:**

| Pension ID or SSN: | Name (Last): | Name (First): | Date of Birth: |
|---|---|---|---|
| Address: | | | Home Phone Number: |
| City: | State: | Zip Code: | Work Phone Number: |

**E. PLEASE LIST ALL FAMILY MEMBERS TO BE COVERED:**

| Last Name | First Name | Date of Birth | Social Security Number | * Primary Care Dentist Name or Code |
|---|---|---|---|---|
| Self | | | | |
| Spouse | | | | |
| Child<br>fulltime student ☐ disabled ☐ | | | | |
| Child<br>fulltime student ☐ disabled ☐ | | | | |
| Child<br>fulltime student ☐ disabled ☐ | | | | |

The dental 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.***

X_____ X_____

**SIGNATURE** **DATE**

860 SILVER LAKE BLVD., SUITE 1 · MCARDLE BUILDING · DOVER, DE 19904 / SLC D570A
PHONE: (302) 739-4208 · TOLL FREE: (800) 722-7300 · FAX: (302) 739-6129 · EMAIL: PENSIONOFFICE@DELAWARE.GOV
WWW.DELAWAREPENSIONS.COM

RESET FORM

# STATE OF DELAWARE
# OFFICE OF PENSIONS

## VISION APPLICATION OR REFUSAL

PLEASE COMPLETE AND RETURN FORM TO THE OFFICE OF PENSIONS

**Effective Date: _____**

**A. PLEASE CHECK THE APPLICABLE BOX OR BOXES:**

| | | |
|---|---|---|
| ☐ New Enrollment | ☐ Termination/Refusal | ☐ Change of Dependents |
| ☐ Coverage Change | ☐ Address Change | ☐ Name Change |

**B. PLEASE SELECT THE COVERAGE OPTION:**

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

**C. PLEASE SELECT ONE VISION PLAN:**

☐ High

☐ Low

**D. PLEASE COMPLETE ALL PERSONAL INFORMATION:**

| Pension ID or SSN: | Name (Last, First, Middle Initial): | | Date of Birth: |
|---|---|---|---|
| Home Address: | | | Home Phone: |
| City: | State: | Zip Code: | Work Phone: |

**E. PLEASE LIST ALL FAMILY MEMBERS TO BE COVERED:**

| Last Name | First Name | Date of Birth | SSN |
|---|---|---|---|
| Self | | | |
| Spouse | | | |
| Child<br>fulltime student ☐ disabled ☐ | | | |
| Child<br>fulltime student ☐ disabled ☐ | | | |
| Child<br>fulltime student ☐ disabled ☐ | | | |

X_____ _____

**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.***

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