

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 DEDS	ONAL								JI G		
A.PERSONAL: Male Female		_	Retiree Dependent Spouse		Pension ID OR SSN:		Agency: OFF		OFFICE OF PENS	FICE OF PENSIONS	
Last Nan	ne:			First Name:		Date of Birth	(month/day/year):	Phone Number:		Alternate Phor	ne Number:
Address:						1		City	:	State:	Zip Code:
B. REAS	ON FOR	APPLIC	CATION:					<u> </u>			
Effective Date:				*ADD DEPENDENTS DUE TO: *Note: Qualifying Event Documentation Is			*CANCEL DEPENDENTS I				
New coverage				Marriage	Adoption / Guardianship		o riequii eu	Divorce	Over age	No longer dependent	
Change coverage			Non-voluntary coverage loss Other Birth			Death	Other				
			ERAGE CHO	CES:		J		Bitti			
COVE	RAGE IS	FOR:					PLEASE MAKE O	NE HEALTHC	ARE COVERAGE	CHOICE:	
Individual Individual & Spouse Indivi			Individual	& Child(ren)	Family	Highmark Delaw	are First State Ba	sic Plan A	Aetna HMO Plan		
Are you eligible for Double State Share? ☐ No			e? 🗌 No	Yes		Highmark Delaw	are Comprehensi	ve PPO Plan A	Aetna Consumer Di	rected Health Gold Plan	
Spousal (Coordinatio	on of Bene	efits (SCOB): If y	ou have selected In	dividual & Spouse	or Family Cov	verage, you <u>MUST</u> comp	•		nt. anytime enrollme	nt or insurance status
							t https://www.delawarep		uponuu oo	,)	nt of insurance status
D. ELIG	IBLE DE	PENDEN	NTS TO BE CO	OVERED / PRIN	MARY CARE P	HYSICIAN S	SELECTION:				
							etwork primary care p	hysician (PCP) for	vourself, snouse and	all eligible denende	nts.
		11 3	ou choose <u>ricinu</u>				lease use a separate for			an engine depende	1651
Name of Yo	ur Primary Care	Physician				Physician's ID Numl	per				
	G 17 1			Ir M		D' d D	la Lagy	I a	I D. G. DI	In I mar	
Add Cancel	Spouse's Last !	Name		First Name		Birth Date	Spouse's SSN	Spo	ouse's Primary Care Physician	Physician's ID Nur	nber
Add	□ Fulltime stud	ent Male	Dependent's Last Name	First Name.		Birth Date	Dependent's SSN	Dep	pendent's Primary Care Physician	Physician's ID Nur	nber
Cancel	Disabled	Female									
Add	Fulltime stud	ent Male	Dependent's Last Name	First Name		Birth Date	Dependent's SSN	Dej	pendent's Primary Care Physician	Physician's ID Nur	nber
Cancel	Disabled	Female									
Add	Fulltime stud	ent Male	Dependent's Last Name	First Name		Birth Date	Dependent's SSN	Dep	pendent's Primary Care Physician	Physician's ID Nur	nber
Cancel	Disabled	Female									
E. TERN	IS OF AG	REEMI	ENT:								
association incomplet that pays informat contract. persons, managen	on and Highte. 3) I autonent will a tion available. 5) I, on been titles or nent, quali-	ghmark I shorize m not be co ble to the chalf of n organiza ty improv	Delaware or Ae y employer, as omplete until ac m concerning a nyself and my of tions for audits yement and assu	tna. 2) I certify the my agent, if applicated the transfer of the my agent, if applicated the my diagnosis, trespondered dependent of the my claims processing and other respondent of the my agent of the my	nat all representa cable to collect to 4) I, on behalf of atment or other its, authorize Hig ng, coordination reasonably related tree to the above to	tions and info he premiums f myself and health care se hmark Delaw of benefits, d d purposes for	ormation supplied by by payroll deduction of my covered depende revices they render to are or Aetna to releast isease management profite the administration of a binding election.	me are true. My or otherwise, for ints, authorize an me or my coverse appropriate derograms, member of this contract or a reference of the contract of the con	coverage shall be vo emittance to Highma y physician, hospital ed dependents its des nographic information r satisfaction surveys	id if any or part of ark Delaware or Ae I or any other hea signee for purpose on, diagnostic and s, other party liabil tate Health Insuran	ract between my employer this application is false of that, with the understanding the care provider to release reasonably related to the medical conditions to other ity, utilization review, cased.
SIGNATURE					ATE		SIGNATURE			DATE	
RETURN THIS FORM TO: Office of Pensions 860							EAV 202 730	2-0-1			