



STATE OF DELAWARE
OFFICE OF PENSIONS

NON-MEDICARE
HEALTH APPLICATION

PLEASE COMPLETE AND RETURN FORM TO PENSION.FORMS@DELAWARE.GOV

If refusing coverage, please complete Section A and sign the refusal on page 3.

A. Personal

☐ Male ☐ Female | ☐ Retiree ☐ Spouse ☐ Dependent

Pension ID or SSN: _____ Agency: OFFICE OF PENSIONS

Last Name: _____ First Name: _____

Date of Birth: _____ Phone: _____ Alt Phone: _____

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 ☐ Death ☐ Over Age ☐ No Longer Dependent ☐ Other

C. Health Care Coverage Choices

Coverage is for: ☐ Individual ☐ Individual and Spouse ☐ Individual and 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 (Physician ID REQUIRED)

☐ 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 more space is needed to list dependents, please use a separate form and attach it to this application.

Personal Information

*Aetna HMO Primary Care Physician ID Required: _____

Spousal Information ☐ Add ☐ Cancel

Last Name: _____ First Name: _____

Birth Date: _____ SSN: _____

*Aetna HMO Primary Care Physician ID Required: _____

Dependent Information ☐ Add ☐ Cancel

☐ Fulltime Student ☐ Disabled | ☐ Male ☐ Female

Last Name: _____ First Name: _____

Birth Date: _____ SSN: _____

*Aetna HMO Primary Care Physician ID Required: _____

Dependent Information ☐ Add ☐ Cancel

☐ Fulltime Student ☐ Disabled | ☐ Male ☐ Female

Last Name: _____ First Name: _____

Birth Date: _____ SSN: _____

*Aetna HMO Primary Care Physician ID Required: _____

Dependent Information ☐ Add ☐ Cancel

☐ Fulltime Student ☐ Disabled | ☐ Male ☐ Female

Last Name: _____ First Name: _____

Birth Date: _____ SSN: _____

*Aetna HMO Primary Care Physician ID Required: _____

*If you choose Aetna HMO coverage, you MUST include an in-network primary care physician ID, for yourself, spouse and all eligible dependents.

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.

Signature

Date

I REFUSE to participate in the State Health Insurance.

Signature

Date

Addendum to Non-Medicare Health Application – Additional Dependents Information

Dependent Information ☐ Add ☐ Cancel

☐ Fulltime Student ☐ Disabled | ☐ Male ☐ Female

Last Name: _____ First Name: _____

Birth Date: _____ SSN: _____

*Aetna HMO Primary Care Physician ID Required: _____

Dependent Information ☐ Add ☐ Cancel

☐ Fulltime Student ☐ Disabled | ☐ Male ☐ Female

Last Name: _____ First Name: _____

Birth Date: _____ SSN: _____

*Aetna HMO Primary Care Physician ID Required: _____

Dependent Information ☐ Add ☐ Cancel

☐ Fulltime Student ☐ Disabled | ☐ Male ☐ Female

Last Name: _____ First Name: _____

Birth Date: _____ SSN: _____

*Aetna HMO Primary Care Physician ID Required: _____

Dependent Information ☐ Add ☐ Cancel

☐ Fulltime Student ☐ Disabled | ☐ Male ☐ Female

Last Name: _____ First Name: _____

Birth Date: _____ SSN: _____

*Aetna HMO Primary Care Physician ID Required: _____

Dependent Information ☐ Add ☐ Cancel

☐ Fulltime Student ☐ Disabled | ☐ Male ☐ Female

Last Name: _____ First Name: _____

Birth Date: _____ SSN: _____

*Aetna HMO Primary Care Physician ID Required: _____
