



**STATE OF DELAWARE
OFFICE OF PENSIONS**

**SPECIAL MEDICFILL
HEALTH APPLICATION
(MEDICARE SUPPLEMENT)**

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

A. Personal

☐ Male ☐ Female | ☐ Retiree ☐ Spouse ☐ Dependent

Pension ID or SSN: _____ Agency: OFFICE OF PENSIONS

First Name & Middle Initial: _____ Last Name: _____

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

Address: _____

City: _____ State: _____ Zip Code: _____

B. Reason For Application

Effective Date: _____

☐ New Coverage

☐ Change Coverage

☐ Information Change

☐ Double State Share Eligible

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 Number: _____

Part A Effective Date: _____

Part B Effective Date: _____

D. Other Coverage Information

Are you covered by other health insurance? ☐ Yes ☐ No

If YES, is this coverage an Advantage Plan? ☐ Yes ☐ No

Are you covered by another Part D qualified prescription plan? ☐ Yes ☐ No

Name of other Insurance Company: _____

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

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.

Signature _____ Date _____

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

(**IMPORTANT:** If you terminate or refuse coverage, you and your eligible dependents will have no health and prescription plan coverage through the State of Delaware.)

Signature _____ Date _____