Revised February 2017

STATE OF DELAWARE OFFICE OF PENSIONS
APPLICATION FOR HEALTH CARE COVERAGE

A. REASON FOR APPLICATION

☐New coverage
☐Change coverage
☐Information change
☐Medicare Eligible
☐Refuse coverage *(see Section F)*

ADD DEPENDENTS DUE TO:
Date of event checked: ____________
☐ Marriage/Civil Union
☐ Non-voluntary coverage loss
☐ Birth ☐ Other
☐ Adoption/Guardianship

CANCEL DEPENDENTS DUE TO:
Date of event checked: ____________
☐Divorce ☐ Death
☐Over age ☐ Other
☐No longer dependent

REINSTATE COVERAGE DUE TO:
Date of event checked: _____________
☐Administrative error
☐Other

B. PERSONAL INFORMATION

☐ Male ☐ Female ☐ Retiree ☐ Surviving spouse ☐ Non-employee	Date of Retirement (month, day, year)	Social Security Number	Agency or School District PENSION OFFICE		
Last Name	First Name	M.I.	Date of Birth (month, day, year)	Home Phone (include area code)	Business Phone (include area code)
Street Address		City	State	Zip Code	

C. HEALTH CARE COVERAGE CHOICES

COVERAGE IS FOR: ☐ Individual ☐ Individual & Spouse ☐ Individual & child (ren) ☐Family

**Relationship of Spouse applies to Spouse or Civil Union Spouse*
**Relationship of Dependent applies to Dependent(s) and/or Civil Union Dependent(s)*

PLEASE MAKE ONE HEALTHCARE COVERAGE CHOICE:

☐Highmark First State Basic ☐Aetna HMO
☐ Highmark Comprehensive PPO ☐Aetna Consumer Directed Health Gold

OR

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.

Applicant's Medicare #: ________________________

Part A Effective Date: ________________________

Part B Effective Date: ________________________

D. ELIGIBLE DEPENDENTS TO BE COVERED / PRIMARY CARE PHYSICIAN SELECTION

***If you choose Aetna HMO coverage, you MUST select a primary care physician (PCP) for yourself, spouse and all eligible dependents**
If more space Is needed to list dependents, please use a separate sheet of paper and attach It to this application.

Name of Your Pri mary Care Physician	Physician's ID Number	Is this your current physician? ☐YES ☐NO

	First Name	M.I.	Last Name (if different), Jr., Sr.	Birth Date	Social Security Number	Primary Care Physician	Physician's ID Number	Current physician?
☐Add ☐ Cancel	Spouse's First Name	M.I.	Last Name (if different), Jr., Sr.	Birth Date / /	Spouse's Social Security Number	Spouse's Primary Care Physician	Physician's ID Number	Spouse's current physician? ☐Y ☐N
☐Add ☐Cancel	Dependent's First Name ☐ Fulltime student ☐Male ☐ Handicapped ☐Female	M.I.	Last Name (if different), Jr., Sr.	Birth Date / /	Dependent's Social Security Number	Dependent's Primary Care Physician	Physician's ID Number	Dependent's current physician? ☐Y ☐N
☐Add ☐Cancel	Dependent's First Name ☐ Fulltime student ☐Male ☐ Handicapped ☐Female	M.I.	Last Name (if different), Jr., Sr.	Birth Date / /	Dependent's Social Security Number	Dependent's Primary Care Physician	Physician's ID Number	Dependent's current physician? ☐Y ☐N
☐Add ☐Cancel	Dependent's First Name ☐ Fulltime student ☐Male ☐ Handicapped ☐Female	M.I.	Last Name (if different), Jr., Sr.	Birth Date / /	Dependent's Social Security Number	Dependent's Primary Care Physician	Physician's ID Number	Dependent's current physician? ☐Y ☐N

E. OTHER COVERAGE INFORMATION

Anyone covered by other health insurance? ☐I am ☐My spouse ☐ My dependent child(ren)	If YES, and the coverage is through an employer, list name of employer below:	Name and Location of Other Insurance Company	Transferring your coverage from another Blue Cross Blue Shield contract? ☐Y ☐N

F. 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 do agree to the above terms.

Signature:_______________________________________Date:_____________

I elect **NOT** to participate in the State Health Insurance.

Signature: ______________________________________Date:__________________

RESET FORM PRINT

State Of Delaware Office Of Pensions
Dental Application

Effective Date

M	M	D	D	Y	Y	Y	Y

Please check the applicable box or boxes.

☐ New enrollment	☐ Name Change	☐ Change of dependents
☐ Coverage Change	☐ Address Change	☐ Termination

Please select who coverage is for:	Please select one dental plan of your choice:
☐ Employee	☐ Delta Dental #1260-0001
☐ Employee & Spouse	☐ Dominion Dental #15339-*Must provide Dentist
☐ Employee & Child(ren)	
☐ Family	

NOTE: INCOMPLETE INFORMATION ON THIS FORM WILL DELAY YOUR ENROLLMENT. PLEASE PRINT CLEARLY.

Social Security Number	Employee Name (Last ,First, Middle Initial)		Date of Birth
Home Address			Home Phone
City	State	Zip Code	Work Phone
Date of Marriage	Marital Status ☐ Single ☐ Married/Civil Union ☐ Widowed ☐ Divorced ☐ Separated		
Agency PENSION OFFICE	*Relationship of Spouse applies to Spouse or Civil Union Spouse *Relationship of Dependent applies to Dependent(s) and/or Civil Union Dependent(s)		

PLEASE LIST HERE ALL FAMILY MEMBERS TO BE COVERED BY THIS ENROLLMENT

Last Name	First Name	MI	Sex	Date of Birth	Social Security	*Primary Care Dentist Name	*Primary Care Dentist Code
Self							
Spouse							
Child ☐ fulltime student ☐ handicapped							
Child ☐ fulltime student ☐ handicapped							
Child ☐ fulltime student ☐ handicapped							

IMPORTANT : Do you or your dependent(s) have other Group Dental Coverage? ☐ YES ☐ NO ☐

If your answer to the above question is yes, please complete the following information.

Name of Insured	Insurance Company	Policy Number
Name of Insured	Insurance Company	Policy Number
Name of Insured	Insurance Company	Policy Number

Employee's Signature_____Date_____

Enrollment/Change Form

Please print and complete all sections.
See instructions below.

Reset Form | Print

Underwritten by Fidelity Security Life Insurance Company of Kansas City, Missouri

EMPLOYER INFORMATION: To be Completed by Employer

Group Number	Employer Name	Effective Date
9812363	State of Delaware	

PENSIONER INFORMATION A: Add (enroll) T: Terminate C: Change (change of name, address or phone)

☐ADD ☐TERM ☐CHG	Gender ☐ M ☐ F	Pensioner ID	Last Name (Pensioner or subscriber)	First Name	M.I.	Date of Birth

Social Security Number	Home Street Address	City/State/Zip	Home Phone

FAMILY INFORMATION (Only those eligible may be enrolled.) A: Add (enroll) T: Terminate C: Change (change of name)

☐A ☐T ☐C	Gender ☐ M ☐ F	Last Name (pensioner)	First Name	M.I.	Date of Birth
☐A ☐T ☐C	Gender ☐ M ☐ F	Last Name (spouse)	First Name	M.I.	Date of Birth
☐A ☐T ☐C	Gender ☐ M ☐ F	Last Name (dependent)	First Name	M.I.	Date of Birth
☐A ☐T ☐C	Gender ☐ M ☐ F	Last Name (dependent)	First Name	M.I.	Date of Birth
☐A ☐T ☐C	Gender ☐ M ☐ F	Last Name (dependent)	First Name	M.I.	Date of Birth

Pensioner Signature: _____ **Date:** _____

Instructions:

Effective date: Beginning date of coverage.
Family Information: List only eligible family members who are enrolling.
Dependent eligibility is the same as employer's health plan.
(A) Add: Open (group) enrollment or new (individual) enrollment during the contract period.
(T) Terminate: To terminate enrollment.
(C) Change: A change of Pensioner name, address or phone

The vision plan is a binding election. Once enrolled, you may not drop coverage during the plan year.

Please note: ***The enrollment form is for the Pension Office's use only and will not be used for any external purpose.***

OFFICE OF PENSIONS

VISION INSURANCE COVERAGE

REFUSAL

I have been advised of the vision plan provided by EyeMed Vision Care.

I elect not to participate in the vision insurance coverage plan offered through the Office of Pensions.

Name: _____

Employee ID: _____

Signature: _____

Social Security # _____

Date: _____

In most cases, future enrollment opportunities in the plans are restricted to an annual reopening.

Form VR (2/2011) §

OFFICE OF PENSIONS

DENTAL INSURANCE COVERAGE

REFUSAL

I elect not to participate in a dental insurance coverage plan offered through the Office of Pensions.

Name: _____

Employee ID: _____

Signature: _____

Social Security # _____

Date: _____

In most cases, future enrollment opportunities in the plans are restricted to an annual reopening.

Form DR (4/2007) §

OFFICE OF PENSIONS

HEALTH INSURANCE COVERAGE

REFUSAL

I elect not to participate in a health insurance coverage plan offered through the Office of Pensions.

Name: _____

Employee ID: _____

Signature: _____

Social Security # _____

Date: _____

In most cases, future enrollment opportunities in the plans are restricted to an annual reopening.

Form DR (4/2007) §