

STATE OF DELAWARE OFFICE OF PENSIONS

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

Revised April 2018

A. REASON FOR APPLICATION

New coverage Change coverage Effective Date of Coverage _____
 Information change Double State Share Eligible

B. PERSONAL INFORMATION

<input type="checkbox"/> Male	<input type="checkbox"/> Retiree	<input type="checkbox"/> Survivor Pensioner	Pension Employee ID OR Social Security Number		PENSION OFFICE		
<input type="checkbox"/> Female	<input type="checkbox"/> Spouse	<input type="checkbox"/> Dependent					
Last Name			First Name	M.I.	Date of Birth (month, day, year)	Primary Phone (XXX-XXX-XXXX)	Other Phone (XXX-XXX-XXXX)
Street Address					City	State	Zip Code

C. HEALTH CARE COVERAGE CHOICES

MEDICARE SUPPLEMENT COVERAGE CHOICE:

**MEDICARE INFORMATION: Must enroll if eligible
Please include copy of signed Medicare card with this application.**

Highmark Special Medicfill with prescription Applicant's Medicare #: _____
 Highmark Special Medicfill **without** prescription Part A Effective Date: _____ Part B Effective Date: _____

E. OTHER COVERAGE INFORMATION

Are you covered by other health insurance? <input type="checkbox"/> Y <input type="checkbox"/> N	If YES, is this coverage an Advantage Plan? <input type="checkbox"/> Y <input type="checkbox"/> N	Are you covered by another Part D qualified prescription plan? <input type="checkbox"/> Y <input type="checkbox"/> N	Name of Other Insurance Company:
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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. 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 do agree to the above terms.

Signature: _____ Date: _____

RETURN THIS FORM TO: Office of Pensions, McArdle Bldg, 860 Silver Lake Blvd, Ste 1, Dover, DE 19904-2402