



# 2016 Health and Life Insurance RETIREE – Election Form

## PRIMARY INFORMATION – please PRINT

Use this form for retirement insurance enrollment or for an eligible qualifying event. **Additional paperwork may be required** (see Required Documentation and Dependent Eligibility document) and return to the OHR Health Insurance Team by the applicable deadline.

Retiree SSN: \_\_\_\_\_

Name: \_\_\_\_\_

Street Address: \_\_\_\_\_

City, State, ZIP Code: \_\_\_\_\_

Telephone Home #: (\_\_\_\_\_) \_\_\_\_\_ – \_\_\_\_\_ Cell #: (\_\_\_\_\_) \_\_\_\_\_ – \_\_\_\_\_

Email Address: \_\_\_\_\_

*Your email address will not be shared and will **only be used by OHR** to contact you regarding your health insurance.*

### Medical (choose one)

- No Medical
- Kaiser HMO (includes Kaiser Rx)
- United HealthCare HMO
- CareFirst POS High Option
- CareFirst POS Standard Option

For eligible participants living outside the POS service area:

- CareFirst POS High Option Out-of-Area
- CareFirst POS Standard Option Out-of-Area

### Dental (choose one)

- No Dental Coverage (2-year waiting period to re-enroll)
- Dental PPO (traditional dental plan)

### Vision Plan (choose one)

- No Vision Coverage
- Discount Vision

### Prescription / Rx (choose one)

*For Kaiser and Indemnity plan participants, no Rx election is needed as Rx coverage is included in your plan*

- No Prescription Coverage
- High Option \$5/\$10
- Standard Option \$10/\$20/\$35

### Optional Life (choose one)

- Cancel Optional Life Coverage
- Keep Current Optional Life Coverage

### Dependent Life (choose one)

- Cancel Dependent Life Coverage
- Keep Current Dependent Life Coverage

## DEPENDENT COVERAGE – please PRINT

To add or delete dependent coverage, complete the section below and **include copies of the required documentation** (e.g., birth certificate, adoption certificate, marriage certificate, etc.) as outlined in the Required Documentation and Dependent Eligibility document. Note that you must have elected the same coverage for yourself in the medical, prescription, dental and/or vision sections of this form as you do below for your dependents (e.g., your dependent may not have the vision plan unless you do). Also, the number of dependents you cover under each plan will determine your coverage level (Self, Self+1 or Family) and your cost for each plan.

Add Eligible Dependent(s)

Keep Same Dependent Coverage

SOCIAL SECURITY <i>(Required)</i>	FULL NAME OF ELIGIBLE DEPENDENT	DATE OF BIRTH	GENDER	RELATIONSHIP	INSURANCE ELECTIONS
					<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Rx <input type="checkbox"/> Vision
					<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Rx <input type="checkbox"/> Vision
					<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Rx <input type="checkbox"/> Vision
					<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Rx <input type="checkbox"/> Vision

Delete / Disenroll Dependent(s)

FULL NAME OF DEPENDENT	NO LONGER ELIGIBLE	COVERAGE TO BE CANCELLED
	<input type="checkbox"/>	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Rx <input type="checkbox"/> Vision
	<input type="checkbox"/>	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Rx <input type="checkbox"/> Vision

## SIGNATURE (must be signed to be effective)

I have read the materials available for the County's Group Insurance Plan. I authorize the County to make a deduction from my ERS or LTD2 benefit for my insurance elections. If I pay directly for insurance, I will promptly pay the cost or benefits will terminate. I understand that I can only change my elections if I have a Status Change (see Summary Description). I also understand that the County may adjust my elections. I authorize the release of enrollment information to the extent necessary to properly administer my elections. I understand that electing benefits to which I or any other person is not entitled is considered fraud and if I misrepresent my eligibility or that of any other person, or fail to take the steps necessary to remove ineligible persons, or in any way obtain benefits to which I am not entitled, benefits will terminate. In addition, I must repay any claims which have been paid inappropriately, and I may face charges. I understand that the County expects to continue the Plan, but it is the County's position that there is no implied contract between members and the County to do so. I also understand that the County reserves the right at any time and for any reason to amend the Plan, subject to any applicable County's collective bargaining agreements. The County may also amend the Plan, prospectively or retroactively to comply with applicable law.

⇒ Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Mail to: OHR Health Insurance Team, 101 Monroe St., 7<sup>th</sup> Floor, Rockville, MD 20850 or fax: 240-777-5131

**Reminder:** When you receive your Medicare card, be sure to send us a copy via fax or to the address above.