2015 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 Insurance Team by the applicable deadline.

Retiree / Employee ID: _____
(at the top of your Fact Sheet or Confirmation Statement)

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 Opt. Out-of-Area (Medical Only)
- ❑ CareFirst POS Standard Opt. Out-of-Area (Medical Only)

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 (2-year waiting period to re-enroll)
- ❑ Discount Vision

Prescription / Rx (choose one)

Kaiser plan participants, no Rx election is needed since Rx coverage is included in your plan

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

Optional Life (choose one)

- ❑ Cancel Optional Life Coverage
- ❑ Keep Current Optional Life Coverage

Reminder: Optional Life Coverage ends at age 70

Dependent Life (choose one)

- ❑ Cancel Dependent Life Coverage
- ❑ Keep Current Dependent Life Coverage

Over ↺

DEPENDENT COVERAGE – Please PRINT

To add or delete dependent coverage, complete the section below and **include copies of the required documentation** (e.g., marriage certificate, birth certificate, adoption certificate, etc.). Note that you must have elected the same coverage for yourself in the Medical, Rx, Dental and/or Vision sections of this form (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 cost for each plan.

❑ **Add Eligible Dependent(s)**

SOCIAL SECURITY NUMBER	FIRST AND LAST NAME OF ELIGIBLE DEPENDENT	DATE OF BIRTH	GENDER	RELATIONSHIP*	INSURANCE ELECTIONS
					❑ Medical ❑ Dental ❑ Rx ❑ Vision
					❑ Medical ❑ Dental ❑ Rx ❑ Vision
					❑ Medical ❑ Dental ❑ Rx ❑ Vision

** Please see the Required Documentation and Dependent Eligibility document* ***DP = Domestic Partner*

❑ **Delete / Disenroll Dependent(s)**

FULL NAME OF DEPENDENT	NO LONGER ELIGIBLE	COVERAGE TO BE CANCELLED
	❑	❑ Medical ❑ Dental ❑ Rx ❑ Vision
	❑	❑ Medical ❑ Dental ❑ Rx ❑ Vision
	❑	❑ Medical ❑ Dental ❑ Rx ❑ Vision

SIGNATURE (must be signed to be effective)

I have read the materials available for the County's Group Insurance Program (Program). 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 during the year 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 willfully misrepresent my eligibility or that of any other person, or fail to take the steps necessary to remove ineligible dependents, or in any way obtain benefits to which I am not entitled, benefits will terminate, I must repay any claims which have been paid inappropriately, and I may face charges. I understand that the County expects to continue the Program, 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 Program, subject to the County's collective bargaining agreements. The County may also amend the Program, prospectively or retroactively to comply with applicable law.

⇨ Signature: _____ Date: _____

IMPORTANT: All forms must be signed and returned to OHR Health Insurance Team within 60 days of a qualified status change event.

- *Mail to:* OHR Health Insurance Team
  101 Monroe St 7th Floor
  Rockville, MD 20850

Fax to: 240-777-5131