2023 Medicare- Eligible Retiree
Return Form To:
Howard County Government Human Resources
3430 Court House Drive
Ellicott City, MD 21043

OHR use only
Effective date: 01/01/2023
Processed Date: _____
OHR Rep: _____

RETIREE NAME: _____

ADDRESS: _____

MEDICAL PLAN SECTION

ENROLLMENT ACTION:
☐ enroll ☐ change plan ☐ add spouse/dependents ☐ delete spouse/dependents ☐ waive or cancel plan

MEDICAL PLAN SELECTION:	**MEDICAL PLAN COVERAGE LEVEL:**	**COST (from rate sheet):**
☐ Kaiser Medicare Advantage Plan	☐ You	$_____
☐ Aetna Medicare Advantage 95 Plan	☐ You & Spouse	$_____
☐ Aetna Medicare Advantage 10 Plan		

MEDICARE ENROLLMENT INFORMATION: – provide your Medicare enrollment information for you and/or your spouse below. Please include a copy of your Medicare ID card along with this enrollment form.

Your Medicare ID #: _____ Spouse Medicare ID#: _____

Your Part A effective date: _____ Spouse Part A effective date: _____

Your Part B effective date: _____ Spouse Part B effective date: _____

END STAGE RENAL DISEASE: – Indicate below if you and/or your spouse are in End Stage Renal Disease

Are you in end stage renal disease? Yes ____ No ____

Is your spouse in end stage renal disease? Yes _____ No _____

RETIREE & DEPENDENT ENROLLMENT INFORMATION:

	Name	**Sex**	**SS#**	**Birth date**	**Medical**
Retiree:					☐
Spouse:					☐

IF ENROLLING IN KAISER HMO, YOU MUST DESIGNATE A KAISER PRIMARY CARE PHYSICIAN (PCP) BELOW FROM THEIR WEBSITES:

Employee: _____ Provider name & number: _____

Spouse: _____ Provider name & number: _____

RETIREE ACKNOWLEDGEMENT & SIGNATURE:

I agree that care providers may furnish information to the insurers I have selected above concerning medical diagnosis, treatments, or services in connection with any condition for which I or my dependents seek care under a Howard County Government benefit plan. I understand that I may not make a benefit election change except in the event of a status change as permitted under IRS regulations. I understand that if a status change occurs I must notify Human Resources **no later than 30 days** from the date of the status change, or I will not be permitted to make a benefit change until the next annual open enrollment period.

RETIREE SIGNATURE: _____ **DATE:** _____

PHONE NUMBER: _____ **EMAIL ADDRESS:** _____