Split Rate
2023
Retiree
Enrollment & Change Form

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

RETIREE NAME: _____

ADDRESS: _____

MEDICAL PLAN ACTION:
[ ] enroll [ ] change plan [ ] add spouse/dependents [ ] delete spouse/dependents [ ] waive or cancel plan

MEDICAL PLAN SELECTION (pre-Medicare):	**MEDICAL PLAN COVERAGE LEVEL:**	**COST (from rate sheet)**
[ ] Kaiser HMO	[ ] You	$_____
[ ] Aetna PPO	[ ] Spouse	$_____
[ ] Aetna Select Open Access	[ ] Other Dependent(s)	$_____

MEDICAL PLAN SELECTION (Medicare-eligible):	**MEDICAL PLAN COVERAGE LEVEL:**	**COST (from rate sheet):**
[ ] Kaiser Medicare Advantage Plus	[ ] You	$_____
[ ] Aetna Medicare Advantage 95 Plan	[ ] Spouse	$_____
[ ] Aetna Medicare Advantage 10 Plan		

MEDICARE ENROLLMENT INFORMATION: – provide Medicare enrollment information below. Include a copy of your Medicare ID card.

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 _____

DENTAL PLAN ACTION:
[ ] enroll [ ] change plan [ ] add spouse/dependents [ ] delete spouse/dependents [ ] waive or cancel plan

DENTAL PLAN SELECTION:	**DENTAL PLAN COVERAGE LEVEL:**	**COST (from rate sheet)**
[ ] Delta Dental PPO Plus	[ ] You	$_____
[ ] Delta Care DHMO	[ ] You & Spouse	$_____
	[ ] You & Children	$_____
	[ ] Family	$_____

RETIREE & DEPENDENT ENROLLMENT INFORMATION:

	Name	**Sex**	**SS#**	**Birth date**	**Medical**	**Dental**
Retiree:					[ ]	[ ]
Spouse:					[ ]	[ ]
Other Dependent(s):					[ ]	[ ]

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

Employee: _____ PCP name & number: _____

Spouse/Other_____ PCP 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 if I elected the one-time opt out feature, I may only re-enroll at a future open enrollment period or due to a qualifying status change. 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: _____