County Flex Benefits
2023
Retiree
Enrollment & Change Form

OHR use only
Effective date: 1/1/2023
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:	**MEDICAL PLAN COVERAGE LEVEL:**	**COST (from rate sheet)**
[ ] Kaiser HMO	[ ] You	$_____
[ ] Aetna PPO	[ ] You & Spouse	$_____
[ ] Aetna Open Access	[ ] You & Children	$_____
	[ ] Family	$_____

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	$_____
[ ] DeltaCare DHMO	[ ] You & Spouse	$_____
	[ ] You & Children	$_____
	[ ] Family	$_____

RETIREE & DEPENDENT ENROLLMENT INFORMATION:

	Name	**Sex**	**SS#**	**Birth date**	**Medical**	**Dental**
Retiree:					[ ]	[ ]
Spouse:					[ ]	[ ]
Child:					[ ]	[ ]
Child:					[ ]	[ ]

if enrolling in Kaiser HMO or DeltaCare DHMO, you must designate a Kaiser primary care physician or DeltaCare DHMO dentist below from their websites.

Employee: _____
Kaiser Provider name & number: _____
DeltaCare provider name & number: _____

Spouse: _____
Kaiser Provider name & number: _____
DeltaCare provider name & number: _____

Child: _____
Kaiser provider name & number: _____
DeltaCare provider name and number: _____

Child: _____
Kaiser provider name & number: _____
DeltaCare provider name and 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:** _____