Employee ID	Effective Date

New Castle County Government
RETIREE GROUP APPLICATION/CHANGE FORM

1. PERSONAL INFORMATION

Social Security Number	[redacted]	Date of Birth:
Last Name	First Name	MI
Street Address		
City	State	Zip
Home Phone Number	Home Email	Other Phone Number

STATUS:	❑ Retired/Pensioner	❑ Survivor	❑ Spouse of Pensioner Insert Name of Pensioner:_____

2. TYPE OF APPLICATION

□ New Application □ Retirement/Date of Event: _____ □ Open Enrollment □ Add Dependent □ Remove Dependent

□ Address Change □ Name Change: From: _____ to _____

Reason for Change:

□ Marriage □ Divorce □ Retirement □ Medicare □ Death □ Other_____ **Date of Event**_____

3. COVERAGE INFORMATION - Is this a change in coverage: HEALTH OR DENTAL □ Yes □ No

4. MEDICAL COVERAGES (Select One) Please check the coverage(s) you want. Check only coverage(s) available in your group.

WAIVE □ HEALTH COVERAGE □ DENTAL COVERAGE **□ Check here if you or any of your dependents under age 65 AND currently have Medicare coverage.**

Retirees under 65	Retirees Over age 65
□ **Highmark Coop 80** (10006174) □ Individual □ Ind./Sp. □ Ind./Child(ren) □ Family	□ **Aetna Medicare Advantage: Classic** □ **Medium RX** □ **High RX**
□ **Highmark Comp 80** (10006175) □ Individual □ Ind./Sp. □ Ind./Child(ren) □ Family	□ **Aetna Medicare Advantage: Preferred Choice** □ **Base RX** □ **Medium RX** □ **High RX**
□ **Highmark PPO** (10006173) □ Individual □ Ind./Sp. □ Ind./Child(ren) □ Family	**Cancel Medical Coverage /Retirees Underage 65** ∟ HM Comp 80 ∟ HM Coop 80 ∟ HM PPO ∟ HM EPO ∟ Aetna Select HMO
□ **Highmark EPO** (10055812) □ Individual □ Ind./Sp. □ Ind./Child(ren) □ Family	**Cancel Medical Coverage /Retirees Over age 65** □ Aetna Medicare Advantage: Classic □ Aetna Medicare Advantage: Preferred
□ **Aetna Select HMO** (834912-010-00002) □ Individual □ Ind./Sp. □ Ind./Child(ren) □ Family	**Cancel Dental** **Cancel Vision** □ **HMO** □ **PPO** □ **EyeMed**

5. DENTAL COVERAGES

Dominion Dental HMO (Select Plan, Group. # 21546)
□ Individual only □ Family
Dental Provider Name & ID # (One dentist per family)

METLIFE PPO DENTAL (HIGH DENTAL PLAN)
(Group # 0243083 Sub-location 007)
□ Individual only □ Employee + One □ Family

METLIFE PPO DENTAL (MEDIUM DENTAL PLAN)
(Group # 0243083 Sub-location 008)
□ Individual only □ Employee + One □ Family

METLIFE PPO DENTAL (LOW DENTAL PLAN)
(Group # 0243083 Sub-location 009)
□ Individual only □ Employee + One □ Family

6. EYEMED VISION PLAN (GROUP # 1002649)

□ Individual □ Ind. + Children □ Ind.+ Spouse □ Family

7. MEDICARE – ELIGIBLE APPLICANTS

ENTER REQUESTED INFORMATION FROM YOUR MEDICARE HEALTH INSURANCE CARD

Health Insurance Code (ID) Number: _____

Hospital Effective Date (Part A): _____

Medical Effective Date (Part B): _____

8. Complete the information for *yourself* and any dependents being provided coverage. For additional dependents attach a separate list (if necessary).

Add	Remove	Continue	Name (Include last name if different from applicant)	SEX	DATE OF BIRTH Month/Day/Year	SOC SEC NUMBER	√ IF DEPENDENT TO BE COVERED BY	√ IF DEPENDENT TO BE COVERED BY DENTAL	√ IF DEPENDENT TO BE COVERED BY VISION	HANDICAPPED (PLEASE ATTACH VERIFICATION)
			Self	☐ M ☐ F						
			Spouse	☐ M ☐ F						
			Child(ren)	☐ M ☐ F						Yes ☐ No ☐
				☐ M ☐ F						Yes ☐ No ☐
				☐ M ☐ F						Yes ☐ No ☐

Please indicate other health for which YOUR dependents are currently enrolled:

Name of Insured	Name of Plan	Plan Location (City, State)	ID or Policy No.

If removing family member, please provide his/her current address:

Name	Address	City, State, Zip

1. **Rights to service are subject to acceptance of this application and to the terms and conditions specified in the present contract and any future contract between my employer and health carrier.**
2. **I certify that all representations and information supplied by me are true. My coverage shall be void if any part of this application is false or incomplete.**
3. **I authorize my employer, as my agent, if applicable to collect premiums by payroll deduction, for remittance to the carrier, with the understanding that payment will not be complete until actually received by the carrier.**
4. **I authorize any physician, hospital or any other health care provider to release information available to them as to diagnosis, treatment or any other health care services they render to me or my covered dependents to my designated carrier or their legal representative.**
5. **I also authorize my designated carrier to release appropriate diagnostic and medical information to other persons in connection with a claim for coordination of benefits, or other purposes related to this contract.**

9. PLEASE SIGN AND DATE BELOW:

The information supplied on this application is accurate and complete to the best of my knowledge and I have read and agree to the terms set forth on the reverse side of this form.

Sign Here ⟶ _____ Date _____