

**STATE OF DELAWARE OFFICE OF PENSIONS
APPLICATION FOR HEALTH CARE COVERAGE**

Revised March 2014

A. REASON FOR APPLICATION

- New coverage
- Change coverage
- Information change
- Medicare Eligible
- Refuse coverage (see Section F)

ADD DEPENDENTS DUE TO:

- Date of event checked: _____
- Marriage/Civil Union
 - Non-voluntary coverage loss
 - Birth Other
 - Adoption/Guardianship

CANCEL DEPENDENTS DUE TO:

- Date of event checked: _____
- Divorce
 - Over age
 - No longer dependent
 - Death
 - Other

REINSTATE COVERAGE DUE TO:

- Date of event checked: _____
- Administrative error
 - Other

B. PERSONAL INFORMATION

| | | | | | | | | | |
|---------------------------------|---|---------------------------------------|---------------------------------------|--|------------------------|------------------------------------|---------------------------|--------------------------------|----------|
| <input type="checkbox"/> Male | <input type="checkbox"/> Retiree | <input type="checkbox"/> Non-employee | Date of Retirement (month, day, year) | | Social Security Number | | Agency or School District | | |
| <input type="checkbox"/> Female | <input type="checkbox"/> Surviving spouse | | | | | | PENSION OFFICE | | |
| Last Name | | | First Name | | M.I. | Date of Birth (month, day, year) | | Home Phone (include area code) | |
| Street Address | | | | | | | City | State | Zip Code |
| | | | | | | Business Phone (include area code) | | | |

C. HEALTH CARE COVERAGE CHOICES

COVERAGE IS FOR: Individual Individual & Spouse Individual & child (ren) Family

**Relationship of Spouse applies to Spouse or Civil Union Spouse*

**Relationship of Dependent applies to Dependent(s) and/or Civil Union Dependent(s)*

PLEASE MAKE ONE HEALTHCARE COVERAGE CHOICE:

- Highmark First State Basic Highmark IPA/HMO Aetna HMO Highmark Comp PPO
- Highmark Consumer Directed Health Gold Aetna Consumer Directed Health Gold

OR

MEDICARE SUPPLEMENT COVERAGE CHOICE:

- Highmark Special Medicfill with prescription Highmark Special Medicfill without prescription

MEDICARE INFORMATION: Must enroll if eligible

Please include copy of Medicare card with this application.

Applicant's Medicare #: _____

Part A Effective Date: _____

Part B Effective Date: _____

D. ELIGIBLE DEPENDENTS TO BE COVERED / PRIMARY CARE PHYSICIAN SELECTION

***If you choose Highmark DE IPA/HMO or Aetna HMO coverage, you MUST select a primary care physician (PCP) for yourself, spouse and all eligible dependents
If more space is needed to list dependents, please use a separate sheet of paper and attach it to this application.**

| | | | | | | | | | | | |
|---|---|--|------|------------------------------------|--|---|------------------------------------|--|------------------------------------|-----------------------|--|
| Name of Your Primary Care Physician | | | | Physician's ID Number | | Is this your current physician? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | | | |
| <input type="checkbox"/> Add <input type="checkbox"/> Cancel | Spouse's First Name | | M.I. | Last Name (if different), Jr., Sr. | | Birth Date / / | Spouse's Social Security Number | | Spouse's Primary Care Physician | Physician's ID Number | Spouse's current physician? <input type="checkbox"/> Y <input type="checkbox"/> N |
| <input type="checkbox"/> Add <input type="checkbox"/> Cancel | Dependent's First Name <input type="checkbox"/> Fulltime student <input type="checkbox"/> Male <input type="checkbox"/> Handicapped <input type="checkbox"/> Female | | M.I. | Last Name (if different), Jr., Sr. | | Birth Date / / | Dependent's Social Security Number | | Dependent's Primary Care Physician | Physician's ID Number | Dependent's current physician? <input type="checkbox"/> Y <input type="checkbox"/> N |
| <input type="checkbox"/> Add <input type="checkbox"/> Cancel | Dependent's First Name <input type="checkbox"/> Fulltime student <input type="checkbox"/> Male <input type="checkbox"/> Handicapped <input type="checkbox"/> Female | | M.I. | Last Name (if different), Jr., Sr. | | Birth Date / / | Dependent's Social Security Number | | Dependent's Primary Care Physician | Physician's ID Number | Dependent's current physician? <input type="checkbox"/> Y <input type="checkbox"/> N |
| <input type="checkbox"/> Add <input type="checkbox"/> Cancel | Dependent's First Name <input type="checkbox"/> Fulltime student <input type="checkbox"/> Male <input type="checkbox"/> Handicapped <input type="checkbox"/> Female | | M.I. | Last Name (if different), Jr., Sr. | | Birth Date / / | Dependent's Social Security Number | | Dependent's Primary Care Physician | Physician's ID Number | Dependent's current physician? <input type="checkbox"/> Y <input type="checkbox"/> N |

E. OTHER COVERAGE INFORMATION

| | | | | | | | |
|--|--|---|--|--|--|--|--|
| Anyone covered by other health insurance? <input type="checkbox"/> I am <input type="checkbox"/> My spouse <input type="checkbox"/> My dependent child(ren) | | If YES, and the coverage is through an employer, list name of employer below: | | Name and Location of Other Insurance Company | | Transferring your coverage from another Blue Cross Blue Shield contract? <input type="checkbox"/> Y <input type="checkbox"/> N | |
|--|--|---|--|--|--|--|--|

F. TERMS OF AGREEMENT

I understand that: 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, association and Highmark Delaware or Aetna. 2) I certify that all representations and information supplied by me are true. My coverage shall be void if any or part of this application is false or incomplete. 3) I authorize my employer, as my agent, if applicable to collect the premiums by payroll deduction or otherwise, for remittance to Highmark Delaware or Aetna, with the understanding that payment will not be complete until actually received. 4) I, on behalf of myself and my covered dependents, authorize any physician, hospital or any other health care provider to release information available to them concerning any diagnosis

treatment or other health care services they render to me or my covered dependents its designee for purposes reasonably related to this contract. 5) I, on behalf of myself and my covered dependents, authorize Highmark Delaware or Aetna to release appropriate demographic information, diagnostic and medical conditions to other persons, entities or organizations for audits, claims processing, coordination of benefits, disease management programs, member satisfaction surveys, other party liability, utilization review, case management, quality improvement and assurance and other reasonably related purposes for the administration of this contract or as required by law.

I **ELECT** to participate in the State Health Insurance and do agree to the above terms.

I elect **NOT** to participate in the State Health Insurance.

Signature: _____ Date: _____

Signature: _____ Date: _____