RETIREE BENEFITS ENROLLMENT FORM
Office of Employee Benefits

Event: Retirement ___
Event: * Open Enrollment ___
Event: Qualified Life Change ___
Effective Date: _____

**** If using this form for Open Enrollment changes, the effective date will always be the start of the new plan year.**

INSTRUCTIONS:

Step 1: To enroll in **Retiree Health** coverage, complete the section below.

Retiree Info: Last Name:_____**First Name:**_____**MI:**__ **SSN:**_____

Date of Birth:_____**Gender:**_____**Address:**_____

Medicare #:_____**Medicare Part A Date:**_____ **Medicare Part B Date:**_____

Step 2: To enroll **eligible dependents**, provide the requested information below**.**

01# (Legal Spouse) Last Name:_____**First Name:**_____**MI:**___**SSN:**_____

Date of Birth:_____**Gender:**_____**Address:** _____

Medicare #:_____**Medicare Part A Date:**_____ **Medicare Part B Date:**_____

Medical & Dental (Y/N):_____ **Prescription (Y/N):**_____

02# (Child) Last Name:_____**First Name:**_____**MI:**____**SSN:** _____

Date of Birth:_____**Gender:**_____**Address:** _____

Medicare #:_____ **Medicare Part A Date:**_____ **Medicare Part B Date:**_____

Medical & Dental (Y/N):_____ **Prescription (Y/N):**_____

03# (Child) Last Name:_____**First Name:**_____**MI:**____**SSN:** _____

Date of Birth:_____**Gender:**_____**Address:** _____

Medicare #:_____ **Medicare Part A Date:**_____ **Medicare Part B Date:**_____

Medical & Dental (Y/N):_____ **Prescription (Y/N):**_____

04# (Child) Last Name:_____**First Name:**_____**MI:**____**SSN:** _____

Date of Birth:_____**Gender:**_____**Address:** _____

Medicare #:_____ **Medicare Part A Date:**_____ **Medicare Part B Date:**_____

Medical & Dental (Y/N): _____ **Prescription (Y/N):**_____

NOTE: Additional dependent entries can be found on page 4

Step 3: Review the rate chart and plan information in the Retiree Benefits Book and select your plan option below and fill in the monthly cost.

All Enrollees are Non-Medicare

___**BlueChoice Advantage PPO High Option & CVS High Option Prescription Drug Plan**

___**BlueChoice Advantage PPO High Option &** No Prescription Drug Plan

___**BlueChoice Advantage PPO Standard & CVS Standard Prescription Drug Plan**

___**BlueChoice Advantage PPO Standard Plan &** No Prescription Drug Plan

___ **United Concordia DHMO Dental Plan**** (No cost to retiree for any coverage level)

Monthly Cost: _____

**If you live or relocate outside of the DHMO coverage area you will be moved to the Dental PPO plan.

All Enrollees are Medicare Eligible with BOTH Medicare A & B

___**Aetna MAPD Plan (Medical & Prescription Drug)** United Concordia Dental is not available if enrolled in this option**.**

___**Kaiser MAPD Plan (Medical & Prescription Drug)** Dental coverage is through Kaiser. Contact Kaiser for details.

Monthly Cost: _____

Retiree with Medicare A Only or Medicare B Only and/ or a Non-Medicare Enrollee(s)

___**Aetna PPO & CVS High Option Prescription Drug Plan**

___**Aetna PPO &** No Prescription Drug Plan

___**United Concordia DHMO Dental Plan**** (No cost to retiree for any coverage level)

Monthly Cost: _____

**If you live or relocate outside of the DHMO coverage area you will be moved to the Dental PPO plan.

** United Concordia Dental is not available for enrollees with Medicare A or B or both A&B

At Least One Enrollee is Medicare Eligible with BOTH Medicare A & B (Split Plan)

___**Aetna MAPD Plan (Medical & Prescription) (Enrollees with Medicare A&B)**

Aetna PPO & CVS High Option Prescription Drug Plan (Enrollees without Medicare A&B)

___**Aetna MAPD Plan (Medical & Prescription) (Enrollees with Medicare A&B)**

Aetna PPO & No Prescription Drug Plan **(Enrollees without Medicare A&B)**

___**Kaiser MAPD Plan (Medical & Prescription) (Enrollees with Medicare A&B)**

Kaiser HMO Plan & CVS High Option Prescription Drug Plan (Enrollees without Medicare A&B)

___**Kaiser MAPD Plan (Medical & Prescription) (Enrollees with Medicare A&B)**

Kaiser HMO Plan & No Prescription Drug Plan **(Enrollees without Medicare A&B)**

Monthly Cost: _____

***Please note: If enrolled in Aetna MAPD or Kaiser MAPD plans,** United Concordia Dental is not available. If enrolled in **Kaiser MAPD Plan** Dental coverage is provided through Kaiser. For details on Kaiser Dental contact Kaiser.

Important Information About Retiree Health Enrollments for Medicare Eligible Retiree and or Dependents:
Retirees and covered dependents enrolled in Medicare Parts A&B will be migrated to a MAPD plan if and when CMS confirms enrollment in Medicare Parts A &B. If you are migrated to Aetna MAPD you will lose Dental coverage at that time. Those migrated to Kaiser MAPD will be allowed to continue Dental coverage. Dependents cannot be enrolled in Dental without a retiree also enrolled.

Important Information About Vision Coverage:
Vision coverage is provided at no cost to Fire, Police, and MAPS retirees

Important Information About The BlueChoice Advantage PPO & AETNA MAPD Plans:

Members that elect The BlueChoice Advantage PPO High/Standard Option Plan and become eligible for Medicare Parts A&B dueto attaining age 65 or enrolling into Medicare Parts A&B will automatically be enrolled in the **AETNA MAPD** Plan with no dental coverage. If you or your dependents become eligible for Medicare Parts A&B due to a disability determined by the Social Security Administration, a copy of the Medicare card must be submitted to Employee Benefits in order to initiate the enrollment into the **AETNA MAPD** Plan. If you should decide that you do not want to be enrolled in the MAPD plan offered by Aetna then you must notify the office of Employee Benefits immediately on 410.396.5830. You may also submit your request to opt out in writing to the Office of Employee Benefits, 7 E. Redwood Street, 20th floor, Baltimore MD 21202.

Important Information About the Kaiser Permanente HMO and Kaiser Permanente MAPD Plan:
Members (retirees or covered dependents) that elect the Kaiser Permanente HMO Plan and are Medicare eligible or become Medicare eligible must notify the Office of Employee Benefits of your enrollment in both Medicare Parts A&B. Please send a copy of your Medicare ID Card to our office. Once we receive the Medicare Card, we will enroll you in the Kaiser Medicare Advantage Plan (MAPD). Upon enrollment in the Kaiser Medicare Advantage Plan, you will receive an Opt-Out letter in the mail from Kaiser. If you want to remain in the Kaiser MAPD plan, you don't have to do anything, you will remain enrolled. If you should decide that you do not want to be enrolled in the MAPD plan offered by Kaiser then you must notify the Office of Employee Benefits immediately on 410.396.5830. You may also submit your request to opt out in writing to the Office of Employee Benefits, 7 E. Redwood Street, 20th floor, Baltimore MD 21202.

Step 4: Documentation is required for newly added dependents to show proof of relationship. **Refer to the Required Documentation Form.**

Attach copies of Medicare cards for you and/or your covered dependent(s) along with this completed enrollment form. You and your covered dependents must be enrolled in both Medicare A & B to be eligible for a Medicare Advantage Prescription Plan (MAPD). CMS (Medicare) must approve all MAPD plans.

Step 5: Provide your contact information in the spaces provided below.

Home Phone # _____	**Cell Phone #** _____	**Email:** _____

Step 6: Sign and date this enrollment form. Email/mail this form and a copy of your required documentation *(such as court-certified marriage certificates, birth certificate, etc.)* for newly added dependents and Medicare card for members enrolled in Medicare Part A&B, if applicable, to **Office of Employee Benefits, 7 E. Redwood Street, 20th Floor, Baltimore, MD 21202 by your enrollment form deadline**.

Signature:_____ **Date Signed:** _____

Contact the Office of Employee Benefits with any questions between the hours of 8:30AM and 4:30PM EST on 410.396.5830, select Option 2 (City Retirees) or Option 3 (BCPSS Retirees), then Option 1 to speak with a Benefit Partner.

05# (Child) Last Name:_____**First Name:**_____**MI:**____**SSN:** _____

Date of Birth:_____**Gender:**_____**Address:** _____

Medicare #: _____ **Medicare Part A Date:** _____ **Medicare Part B Date:**_____

Medical & Dental (Y/N):_____ **Prescription (Y/N):**_____ ***Vision (Y/N):** _____

06# (Child) Last Name:_____**First Name:**_____**MI:**____**SSN:** _____

Date of Birth:_____**Gender:**_____**Address:** _____

Medicare #: _____ **Medicare Part A Date:** _____ **Medicare Part B Date:**_____

Medical & Dental (Y/N):_____ **Prescription (Y/N):**_____ ***Vision (Y/N):** _____

07# (Child) Last Name:_____**First Name:**_____**MI:**____**SSN:** _____

Date of Birth:_____**Gender:**_____**Address:** _____

Medicare #: _____ **Medicare Part A Date:** _____ **Medicare Part B Date:**_____

Medical & Dental (Y/N):_____ **Prescription (Y/N):**_____ ***Vision (Y/N):** _____

08# (Child) Last Name:_____**First Name:**_____**MI:**____**SSN:** _____

Date of Birth:_____**Gender:**_____**Address:** _____

Medicare #: _____ **Medicare Part A Date:** _____ **Medicare Part B Date:**_____

Medical & Dental (Y/N):_____ **Prescription (Y/N):**_____ ***Vision (Y/N):** _____

09# (Child) Last Name:_____**First Name:**_____**MI:**____**SSN:** _____

Date of Birth:_____**Gender:**_____**Address:** _____

Medicare #: _____ **Medicare Part A Date:** _____ **Medicare Part B Date:**_____

Medical & Dental (Y/N):_____ **Prescription (Y/N):**_____ ***Vision (Y/N):** _____

010# (Child) Last Name:_____**First Name:**_____**MI:**___**SSN:** _____

Date of Birth:_____**Gender:**_____**Address:** _____

Medicare #: _____ **Medicare Part A Date:** _____ **Medicare Part B Date:**_____

Medical & Dental (Y/N):_____ **Prescription (Y/N):**_____ ***Vision (Y/N):** _____