

BALTIMORE COUNTY GOVERNMENT RETIREE HEALTH INSURANCE APPLICATION

1- Applicant's Personal Information						
Name			Street			
SSN			City	State		Zip
DOB		Primary Phone			Email	
If Widow or Spouse is Applicant: _____ <div style="display: flex; justify-content: space-between;"> Retiree Name Retiree SSN </div>						

To Be Completed by the Insurance Division	
Ben Eff Date:	DPOL:
Date of Event:	Retirement Date:
Benefit Basis:	Entity:
Years of Creditable Service:	
Completed by:	Date:
IMPORTANT – Please provide address for person(s) being removed: _____	

2- Enrollment Type			
Type of Event	Add Dependent(s)	Remove Dependent(s)	
<input type="checkbox"/> New Applicant	<input type="checkbox"/> Loss of other coverage	<input type="checkbox"/> Marriage*	<input type="checkbox"/> Legal Separation / Divorce*
<input type="checkbox"/> Eligible for Medicare: <input type="checkbox"/> Self <input type="checkbox"/> Spouse	<input type="checkbox"/> Gain of other coverage	<input type="checkbox"/> Birth/Adoption of a Child*	<input type="checkbox"/> Child over qualifying age
<input type="checkbox"/> Retirement	<input type="checkbox"/> Open Enrollment	<input type="checkbox"/> Other (please explain)	<input type="checkbox"/> Other (please explain)
* If adding or removing dependent(s), please attach documentation within 31 days of event *Please provide address for person(s) being removed			

3- Benefit Options			
Non-Medicare Retirees / Spouses	Medicare Retirees / Spouses	Dental Plans	Vision Plan
<input type="checkbox"/> Cigna Open Access Plus (OAP – In and Out of Network)	<input type="checkbox"/> Cigna Medicare Surround	<input type="checkbox"/> CareFirst BCBS Traditional Dental	<input type="checkbox"/> CareFirst Davis Vision
<input type="checkbox"/> Cigna Open Access Plus In-Network Only (OAPIN)	<input type="checkbox"/> Kaiser Medicare Plus HMO	<input type="checkbox"/> CareFirst BCBS Preferred PPO	<input type="checkbox"/> Waive Coverage
<input type="checkbox"/> Kaiser Permanente Select HMO	<input type="checkbox"/> Cigna Medicare Surround No Rx	<input type="checkbox"/> Cigna Dental Care HMO	
<input type="checkbox"/> Waive Coverage	<input type="checkbox"/> Waive Coverage	<input type="checkbox"/> Waive Coverage	
Coverage Level : <input type="checkbox"/> IND <input type="checkbox"/> Ret+Sp <input type="checkbox"/> P/C <input type="checkbox"/> FAM		Coverage Level : <input type="checkbox"/> IND <input type="checkbox"/> Ret+Sp <input type="checkbox"/> P/C <input type="checkbox"/> FAM	Coverage Level : <input type="checkbox"/> IND <input type="checkbox"/> Ret+Sp <input type="checkbox"/> P/C <input type="checkbox"/> FAM

4- Dependent(s) Being Added or Removed (Rem)									
Name	Add	Rem	Relationship	Gender	Social Security #	Date of Birth	Disabled Y/ N	Primary Care Doctor (Kaiser ONLY)	Primary Care Dentist (CIGNA ONLY)
RETIREE			SELF						

5-			
Are you eligible for Medicare? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, attach copy of Medicare card	If yes, Medicare No:	Part A Effective Date:	Part B Effective Date:
Spouse eligible? <input type="checkbox"/> YES <input type="checkbox"/> NO Child eligible? <input type="checkbox"/> YES <input type="checkbox"/> NO	If yes, Medicare No:	Part A Effective Date:	Part B Effective Date:

All information I have given on this application is true to the best of my knowledge. I agree to follow the Retiree guidelines and eligibility rules set forth in the Retiree enrollment guide.

Applicant Signature _____ **Date**

Return to: Baltimore County Insurance Division
 400 Washington Ave Room 111
 Towson, MD 21204
 FAX: 410-887-3820 PH: 410-887-2568