# CECIL COUNTY PUBLIC SCHOOLS

## January 1, 2025- December 31, 2025 Retiree Health Benefits Enrollment Form

**CURRENT PERSONAL DATA**

| Retiree Name (First, Last): | | Social Security #: | Gender: | Self Identity: | |
|---|---|---|---|---|---|
| Mailing Address: | | | Phone #: ( ) | Birthdate: | Years of Service: |
| City: | State: | Zip Code: | Email: | | Retirement Date: |

Marital Status: [ ] Married [ ] Widowed [ ] Single

Is Spouse Employed? [ ] Yes [ ] No

**Please remember: Notify the Benefits Office of any change in address or telephone number mid-year.**

If applicable, complete the **Coordination of Benefits** information at bottom of form before signing.

Medicare eligibility affects your medical plan enrollment - be sure to notify the Benefits Office if you become Medicare eligible before age 65.

If you have not done so previously, please provide a copy of your **Medicare Card**.

Now or at the time of retirement will [ ]you, [ ] your spouse or [ ] dependent(s) be Medicare eligible or over age 65? [ ]Yes [ ]No If yes, complete Medicare section below.

**MEDICARE INFORMATION: Complete if any person to be covered is over age 65 or is eligible for Medicare. You must have both Medicare Parts A & B to enroll in a CCPS supplemental**

[ ]Self Medicare #: ____________________ Hospital Part A Effective Date:__________________ Medical Part B Effective Date:__________________

[ ]Spouse [ ]Dependent Medicare #:____________________ Hospital Part A Effective Date:__________________ Medical Part B Effective Date:__________________

**HEALTH CARE ELECTIONS (Benefit Period: January 1, 2025 - December 31, 2025) Choose one for each coverage option.**

| Enrollment Status (Check One) | Medical Options | Dental Options | Vision Options |
|---|---|---|---|
| ☐ Individual | [ ] Enrollment in plan with HRA Contributions/Government Subsidy* | | |
| ☐ Retiree/Spouse | [ ] Spouse's Plan/ New Employer | [ ] United Concordia (UCCI) | [ ] EyeMed Vision (Standard) |
| ☐ Retiree/Child | [ ] CareFirst/BCBS Medi-Comp | [ ] No Dental** | [ ] No Vision** |
| ☐ Retiree/Children | [ ] Aetna Medicare Advantage PPO | | |
| ☐ Family | [ ] No Medical Coverage** | | |

*ONLY FOR NON-MEDICARE ELIGIBLE RETIREES. PLEASE ATTACH CONFIRMATION OF YOUR ENROLLMENT.

**IF YOU WAIVE ANY COVERAGE YOU WILL NOT BE ABLE TO SELECT COVERAGE IN THE FUTURE.

**DEPENDENT INFORMATION: YOU MUST COMPLETE THIS SECTION FOR ANY INDIVIDUAL TO BE COVERED BY THE PLAN.**

| | Last Name | First Name | M.I. | Date of Birth (MM/DD/YY) | Social Security # | Gender | Medicare Eligible *(circle one)* |
|---|---|---|---|---|---|---|---|
| SPOUSE | | | | __ __/__ __/__ __ | | | Y or N |
| CHILD+ | | | | __ __/__ __/__ __ | | | Y or N |
| CHILD+ | | | | __ __/__ __/__ __ | | | Y or N |

+Completed Student Certification for Overage Dependent with student schedule verifying credit hours is required for any dependent over age 19 enrolled in Delta dental, and/or EyeMed vision. If totally disabled prior to age 19, attach proof of disability for eligibility review.

I understand by completing and signing this enrollment form, I am making a binding election with regard to my benefits as indicated. I understand that if I now decline or cancel coverage for which I and my dependents are now eligible, I will not be able to elect coverage at a later date. I also understand that my election for medical, dental and vision coverages will remain in effect in subsequent Plan Years unless I change my election during the Open Enrollment period and I shall be provided written notice regarding the annual enrollment opportunity. I certify that the children for which I have elected coverage are my dependents.

**COORDINATION OF BENEFITS** - Other than Medicare and your CCPS retiree health benefits, do you, your spouse, or any of your covered dependents have other health insurance? ___YES ___NO

Specify who is covered:______________________________Name of Insurance company:____________________________Policy Number: ___________________________ Effective Date:___/___/___

X ______________________________________________ Retiree SIGNATURE

______________________________ DATE

| *FOR OFFICE USE ONLY:* | Type of Enrollment | [ ] New Retirement | Reason for Change [ ]Divorce [ ]Death [ ]Child Eligibility [ ]Retirement [ ]MC Eligible [ ]Other____________ |
|---|---|---|---|
| | | [ ] Change of Enrollment | Effective Date of Insurance Change: _____/_____/______ Payment Type: ____Retirement Deduction ____ Need to Bill |

| AETNA SUBSCRIBERS PLEASE ANSWER THE FOLLOWING QUESTIONS TO HELP COORDINATE YOUR BENEFITS | |
|---|---|
| [ ]YES [ ]NO<br>If Yes:<br>Date _______________<br>(mm/yy) | Do you have End-Stage Renal Disease (ESRD)?<br>If you have had a successful kidney transplant and/or you don't need regular dialysis any more, please attach a note or records from your doctor showing you have had a successful kidney transplant or you don't need dialysis, otherwise we may need to contact you to obtain additional information. |
| [ ]YES [ ]NO | Did you become eligible for Medicare because of ESRD and has it been less than 30 months since you became eligible? |