

CECIL COUNTY PUBLIC SCHOOLS

January 1, 2026- December 31, 2026 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		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 .			
Is Spouse Employed? ☐ Yes ☐ No					
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, 2026 - December 31, 2026) Choose one for each coverage option.

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

*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 Coverage 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 If Yes: Date _____ (mm/yy)	Do you have End-Stage Renal Disease (ESRD)? 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?