CECIL COUNTY PUBLIC SCHOOLS

January 1, 2027- December 31, 2027 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, 2027 - December 31, 2027) 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 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?