

BALTIMORE COUNTY GOVERNMENT RETIREE HEALTH INSURANCE APPLICATION

1- Applicant's Personal Information							
Name				Street			
SSN (Last 4)				City		State	
DOB			Primary Phone			Email	
If Spouse is Applicant: _____							
Retiree Name				Retiree SSN (Last 4)			

To Be Completed by New Retirees Only	
First Day of Retirement:	
Years of Service:	
Department/Division:	
IMPORTANT – Please provide address for person(s) being removed:	

2- Enrollment Type			
Type of Event	Add Dependent(s)	Remove Dependent(s)	
<input type="checkbox"/> Retirement	<input type="checkbox"/> Open Enrollment	<input type="checkbox"/> Legal Separation / Divorce*	
<input type="checkbox"/> New Applicant	<input type="checkbox"/> Gain of other coverage	<input type="checkbox"/> Child over qualifying age	
<input type="checkbox"/> Loss of other coverage	<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		Dental Plans	Vision Plan
<input type="checkbox"/> Cigna Open Access Plus In-Network Only (OAPIN)	<input type="checkbox"/> Cigna High Deductible Health Plan (HDHP)	<input type="checkbox"/> CareFirst BCBS Traditional Dental	<input type="checkbox"/> NVA Vision
<input type="checkbox"/> Cigna Open Access Plus (OAP – In and Out of Network)		<input type="checkbox"/> CareFirst BCBS Preferred PPO	<input type="checkbox"/> Waive Coverage
<input type="checkbox"/> Kaiser Permanente Select HMO		<input type="checkbox"/> Cigna Dental HMO	
<input type="checkbox"/> Waive Coverage		<input type="checkbox"/> Waive Coverage	
Coverage Level : <input type="checkbox"/> IND - Retiree <input type="checkbox"/> Ret+Sp <input type="checkbox"/> P/C <input type="checkbox"/> FAM <input type="checkbox"/> IND – Spouse		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
RETIREE			SELF				

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.

Retiree Signature _____ Date _____

Return to: Baltimore County Insurance Division
400 Washington Ave Room 111
Towson, MD 21204
bcbenefits@baltimorecountymd.gov
Fax: 410-887-3820 Ph: 410-887-2568