RETIREE ENROLLMENT FORM –
CHARLES COUNTY PUBLIC SCHOOLS

Effective Date: 01/01/2021

Last Name		First Name		MI	
Employee #		Home Phone			
Mailing Address					
City		State		Zip Code	

BENEFIT SELECTION

Only complete if you are making a change

HEALTH INSURANCE:

You are currently enrolled in the following plan:	
If you would like to change your plan, select the ***new*** plan to the right in which you would like to enroll.	

Choose One Coverage Level: *Shade in the circle to the left of your selection. Only select one level of coverage.*

Choose from #1 to #2 if no one covered is eligible for Medicare Parts A & B

O Retiree Only, No Medicare

O Retiree, Spouse and/or Child, No Medicare(Family)

Choose from #3 to #7 if anyone covered is eligible for Medicare (the Retiree must be one f the individuals covered):

O Retiree Only (with Medicare Parts A&B)
O Two People (only one with Medicare Parts A&B)
O Two People (both with Medicare Parts A&B)
O Three People (only one with Medicare Parts A&B)
O Three People (only two with Medicare Parts A&B

Medicare Information* – A Beneficiary is considered a "Retiree":** Medicare information must be provided for anyone covered under your Retiree group policy that is eligible for Medicare due to age (age 65) or disability (any age). Medicare-eligible individuals who do not carry both Part A (Hospital) and Part B (Medical) will be responsible for paying the amount that Medicare would have paid (Approximately 80% of all eligible services). For example, a Medicare-eligible Retiree who incurs a $100.00 Part A claim and does not carry Part B, will be responsible for paying the amount that Medicare Part B would have covered (approximately 80%). Medicare rules for End Stage Renal Disease (ESRD) differ; call Office of Fiscal Services- Employee Benefits for more information. ***NOTE: Medicare Part D (Prescription Drug) is Creditable Coverage. If you select a Part D program outside of the plan offered by the Board of Education you and your dependents may loose supplemental coverage.

ENROLLMENT INFORMATION

List Covered Members– All information must be complete. Failure to complete may delay your application coverage.

Employee

Last Name		First Name		MI	
Social Security #		Birthdate		Sex	
Blue Choice Only – Primary Doctor:					
If Eligible for Medicare: Medicare Claim Number:					
Part A Effective date:		Part B Effective date:			

Dependents ☐**Add** ☐**Remove**

Last Name		First Name		MI	
Social Security #		Birthdate		Sex	
Blue Choice Only – Primary Doctor:					
Relationship to Employee:					
If Eligible for Medicare: Medicare Claim Number:					
Part A Effective date:		Part B Effective date:			

☐**Add** ☐**Remove**

Last Name		First Name		MI	
Social Security #		Birthdate		Sex	
Blue Choice Only – Primary Doctor:					
Relationship to Employee:					
If Eligible for Medicare: Medicare Claim Number:					
Part A Effective date:		Part B Effective date:			

☐**Add** ☐**Remove**

Last Name		First Name		MI	
Social Security #		Birthdate		Sex	
Blue Choice Only – Primary Doctor:					
Relationship to Employee:					
If Eligible for Medicare: Medicare Claim Number: Part A Effective date: Part B Effective date:					

Do you or your dependents have other health insurance? ☐ Yes ☐ No
Effective Date of Policy:

Name of primary card holder:		Name of insurance Co:	
Policy group number:		Membership number:	
Name of employer:			

List all individuals covered on other health insurance:

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I understand the benefits and limitations provided by the various plans and I authorize the Board of Education to make the necessary adjustments in my paycheck based on the choices I have made. I agree to make any premium payments necessary if my payroll allowance will not support the necessary deductions. The personal information provided on this enrollment form is complete and accurate. I understand that I cannot cancel or change my enrollment except during an Open Enrollment period or as a result of a qualifying event in accordance with IRS Code Section 125.

I understand that the Benefit Program offered by the Board is subject to modifications and changes. The Board of Education reserves the right to modify any of the benefits provided and gives no assurances, expressed, or implied; that any coverage obtained hereunder will continue beyond December 31, 2023.

I certify that the listed dependents are eligible for coverage under the benefit plan rules. **I also understand that enrollment forms submitted without the required dependent documentation will not be processed.** I understand that enrollment in benefits to which I am or my dependents are not entitled is considered fraud. The recorded answers on this form are to the best of my knowledge and belief, full, complete and true as of this date. In all cases, I am responsible for the accuracy of my benefits, coverage levels and deductions. I further understand that if I willfully misrepresent the eligibility of myself or my dependents on my benefits application, or fail to take the necessary action to remove ineligible dependents, or in any way obtain benefits to which I am not entitled, my benefits will be cancelled and I will be required to repay any claims and/or insurance premiums.

If you have any questions concerning the benefits and services that are provided by or excluded under this agreement, please contact Christeda Warner, Benefits Manager at 301-934-7459 or cwarner@ccboe.com.

_____ _____

Employee Signature: *Date*

Please return your completed form to:
Charles County Public Schools
Office of Fiscal Services- Employee Benefits
P.O. Box 2770
La Plata, MD 20646