

**STATE OF DELAWARE OFFICE OF PENSIONS  
APPLICATION FOR HEALTH CARE COVERAGE**

**A. REASON FOR APPLICATION**

<input type="checkbox"/> New coverage <input type="checkbox"/> Change coverage <input type="checkbox"/> Information change <input type="checkbox"/> Medicare Eligible <input type="checkbox"/> Refuse coverage (see Section E)	<b>ADD DEPENDENTS DUE TO:</b>	<b>CANCEL DEPENDENTS DUE TO:</b>	<b>REINSTATE COVERAGE DUE TO:</b>	
	<input type="checkbox"/> Marriage <input type="checkbox"/> Birth <input type="checkbox"/> Adoption/ Guardianship	<input type="checkbox"/> Non-voluntary coverage loss <input type="checkbox"/> Other	<input type="checkbox"/> Divorce <input type="checkbox"/> Over age <input type="checkbox"/> No longer dependent	<input type="checkbox"/> Death <input type="checkbox"/> Other <input type="checkbox"/> Administrative error <input type="checkbox"/> Other
	Date of event checked:	Date of event checked:	Date of event checked:	

**B. PERSONAL INFORMATION**

<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Retiree <input type="checkbox"/> Surviving spouse <input type="checkbox"/> Non-employee	Date of Retirement (month, day, year)	Social Security Number		Agency or School District <b>PENSION OFFICE</b>	
Last Name	First Name	M.I.	Date of Birth (month, day, year)	Home Phone (include area code)	Business Phone (include area code)
Street Address			City	State	Zip Code

**C. HEALTH CARE COVERAGE CHOICES**

<b>COVERAGE IS FOR:</b> <input type="checkbox"/> Individual <input type="checkbox"/> Individual & Spouse <input type="checkbox"/> Individual & child(ren) <input type="checkbox"/> Family	<b>MEDICARE INFORMATION: Must enroll if eligible</b> Please include copy of Medicare card with this application.
<b>PLEASE MAKE ONE HEALTH CARE COVERAGE CHOICE:</b> <input type="checkbox"/> BCBS First State Basic <input type="checkbox"/> Blue Care (HMO) <input type="checkbox"/> Aetna (HMO) <input type="checkbox"/> BCBS Comprehensive	Applicant's Medicare #:
<b>OR</b>	Part A Effective Date:
<b>MEDICARE SUPPLEMENT COVERAGE CHOICE:</b> <input type="checkbox"/> BCBS Special Medicfill <input type="checkbox"/> Special Medicfill without prescription	Part B Effective Date:

**D. ELIGIBLE DEPENDENTS TO BE COVERED / PRIMARY CARE PHYSICIAN SELECTION**

*\*If you choose Blue Care (HMO) coverage or Aetna, you MUST select a primary care physician (PCP) for yourself, spouse and all eligible dependents  
If more space is needed to list dependents, please use a separate sheet of paper and attach it to this application.*

Name of Your Primary Care Physician		Physician's ID Number		Is this your current physician? <input type="checkbox"/> YES <input type="checkbox"/> NO				
<input type="checkbox"/> Add <input type="checkbox"/> Cancel	Spouse's First Name	M.I.	Last Name (if different), Jr., Sr.	Birth Date / /	Spouse's Social Security Number	Spouse's Primary Care Physician	Physician's ID Number	Spouse's current physician? <input type="checkbox"/> Y <input type="checkbox"/> N
<input type="checkbox"/> Add <input type="checkbox"/> Cancel	Dependent's First Name <input type="checkbox"/> Fulltime student <input type="checkbox"/> Male <input type="checkbox"/> Handicapped <input type="checkbox"/> Female	M.I.	Last Name (if different), Jr., Sr.	Birth Date / /	Dependent's Social Security Number	Dependent's Primary Care Physician	Physician's ID Number	Dependent's current physician? <input type="checkbox"/> Y <input type="checkbox"/> N
<input type="checkbox"/> Add <input type="checkbox"/> Cancel	Dependent's First Name <input type="checkbox"/> Fulltime student <input type="checkbox"/> Male <input type="checkbox"/> Handicapped <input type="checkbox"/> Female	M.I.	Last Name (if different), Jr., Sr.	Birth Date / /	Dependent's Social Security Number	Dependent's Primary Care Physician	Physician's ID Number	Dependent's current physician? <input type="checkbox"/> Y <input type="checkbox"/> N
<input type="checkbox"/> Add <input type="checkbox"/> Cancel	Dependent's First Name <input type="checkbox"/> Fulltime student <input type="checkbox"/> Male <input type="checkbox"/> Handicapped <input type="checkbox"/> Female	M.I.	Last Name (if different), Jr., Sr.	Birth Date / /	Dependent's Social Security Number	Dependent's Primary Care Physician	Physician's ID Number	Dependent's current physician? <input type="checkbox"/> Y <input type="checkbox"/> N

**E. OTHER COVERAGE INFORMATION**

Anyone covered by other health insurance? <input type="checkbox"/> I am <input type="checkbox"/> My spouse <input type="checkbox"/> My dependent child(ren)	If YES, and the coverage is through an employer, list name of employer:	Name and Location of Other Insurance Company	Transferring your coverage from another Blue Cross Blue Shield contract? <input type="checkbox"/> Y <input type="checkbox"/> N
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**F. TERMS OF AGREEMENT**

**I understand that:** 1) Rights to service are subject to acceptance of this application and to the terms and conditions specified in the present contract and any future contract between my employer, association and Blue Cross Blue Shield of Delaware (BCBSD) or Aetna. 2) I certify that all representations and information supplied by me are true. My coverage shall be void if any or part of this application is false or incomplete. 3) I authorize my employer, as my agent, if applicable to collect the premiums by payroll deduction or otherwise, for remittance to BCBSD or Aetna, with the understanding that payment will not be complete until actually received. 4) I, on behalf of myself and my covered dependents, authorize any physician, hospital or any other health care provider to release information available to them concerning any diagnosis, treatment or other health care services they render to me or my covered dependents its designee for purposes reasonably related to this contract. 5) I, on behalf of myself and my covered dependents, authorize BCBSD or Aetna to release appropriate demographic information, diagnostic and medical conditions to other persons, entities or organizations for audits, claims processing, coordination of benefits, disease management programs, member satisfaction surveys, other party liability, utilization review, case management, quality improvement and assurance and other reasonably related purposes for the administration of this contract or as required by law.

I **ELECT** to participate in the State Health Insurance and do agree to the above terms.

I elect **NOT** to participate in the State Health Insurance.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_