Kent County Retiree Benefit Election Form

Date of Event: ____/____/____

Effective Date: *(H.R. Use Only)* ____/____/____

Privacy No.: *(H.R. Use Only)* _____

☐ Marriage* ☐ Birth/Adoption* ☐ Medicare Eligible* ☐ Loss of Coverage* ☐ Name/Address Change ☐ Open Enrollment _____ (year)

☐ Divorce* ☐ Add Dependent(s)* ☐ Delete Dependent(s) ☐ Other _____

*Documentation Necessary

Retiree Social Security No.	Retiree Last Name	Retiree First Name	M.I.	Sex	Birthdate	Phone

Home Address	City	State	Zip	Email

List all dependents below

Check One	Last Name	First Name	M.I.	Sex	Date of Birth	Social Security No.	Relationship
Spouse Add ☐ Delete ☐							
Dep-1 Add ☐ Delete ☐							
Dep-2 Add ☐ Delete ☐							
Dep-3 Add ☐ Delete ☐							

Medical Coverage - Non-Medicare

	BCBS PPO	BCN HMO	Waive Coverage
Retiree	☐	☐	☐
Spouse	☐	☐	☐
Dependent(s)	☐	☐	☐

Prescription Coverage - Non-Medicare

	Capital Rx	Waive Coverage
Retiree	☐	☐
Spouse	☐	☐
Dependent(s)	☐	☐

Vision Coverage

Vision Service Plan

Single ☐ Double ☐ Family ☐ Waive ☐

Dental Coverage

Delta Dental Plan

Single ☐ Double ☐ Family ☐ Waive ☐

Medicare Advantage (Part C) - Administered by AmWINS

	Humana	Waive Coverage
Retiree	☐	☐
Spouse	☐	☐

Other Coverage - Medicare

Are you, your spouse, or dependents Medicare eligible? ☐ yes ☐ no If Yes, please complete Name, Medicare Number and Dates below.

Last Name	First Name	Medicare Number	Part A Effective Date	Part B Effective Date

I understand that the above benefit elections may only be used for me or my dependents as defined under the plan. My benefit elections will remain in effect for the entire plan year, unless I experience a change in my family status. I also understand that I must notify Human Resources within 30 days of the change in my family status in order to change my benefit elections.

Signature: _____ **Date:** _____

Waiver Coverage I wish to waive my medical and prescription benefits. I understand that I will be unable to enroll in health benefits until the next Open Enrollment period unless I experience a change in my family status. I understand that this waiver will become effective the first of the month following receipt of this form by Human Resources. Should I choose to elect coverage during Open Enrollment, my elections will not become effective until January 1st, the beginning of the next plan year.

Signature: _____ **Date:** _____

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