



Anne Arundel County Public Library
Retiree Open Enrollment Health Benefits Form – 2024 Plan Year

Name: _____ SS #: _____ Date of Birth: _____
 Address: _____ City/State/Zip: _____
 Gender: _____ Daytime Phone #: _____ Email Address: _____

Instructions: Use this form to make changes to your benefit elections for the 2024 calendar year. Return the completed form to AACPL Human Resources, 5 Harry Truman Parkway, Annapolis, MD 21401 by October 31, 2023. **No response is necessary if you are not making any changes. If you do not send in a change form, your current elections will be retained.**

Health Care Election- Enter coverage election(s) for 2024 calendar year

<p>Medical Plans</p> <p><input type="checkbox"/> Aetna Open Choice PPO <input type="checkbox"/> Open Access Aetna Select HMO-EPO <input type="checkbox"/> AETNA PPO Extended Service Area (ESA) (Attach copy of Medicare Card)</p> <p><input type="checkbox"/> No Coverage**</p>	<p>Medical Plan Coverage Level</p> <p><input type="checkbox"/> Individual <input type="checkbox"/> Retiree & 1 Child <input type="checkbox"/> Retiree & Spouse <input type="checkbox"/> Family <input type="checkbox"/> Split Option: Retiree's Plan Name _____ Retiree's Spouse Plan Name: _____</p>
<p>Dental Plans</p> <p><input type="checkbox"/> Cigna PPO Dental (Core) <input type="checkbox"/> Cigna PPO Dental (Buy-Up) <input type="checkbox"/> CIGNA Dental Care (DHMO Network Dentist Required)</p> <p><input type="checkbox"/> No Coverage**</p>	<p>Dental Plan Coverage Level</p> <p><input type="checkbox"/> Individual <input type="checkbox"/> Retiree & 1 Child <input type="checkbox"/> Retiree & Spouse <input type="checkbox"/> Family</p>
<p>Vision Plan</p> <p><input type="checkbox"/> EyeMed Vision <input type="checkbox"/> No Coverage**</p>	<p>Vision Plan Coverage Level</p> <p><input type="checkbox"/> Individual <input type="checkbox"/> Retiree & 1 Child <input type="checkbox"/> Retiree & Spouse <input type="checkbox"/> Family</p>

Other Health Coverage? Check here if you or your dependents are covered by another insurance policy

In the section below, list all eligible individuals for whom coverage is requested. Attach copy of Marriage or Birth Certificate if you are adding dependents who were not covered in 2022.

Full Name	Relationship	Social Security Number	Gender	Birth Date
	SELF			

By signing below, I request enrollment as indicated above and agree to pay any premiums required to participate in the selected plans. I certify that any person for whom I am electing coverage meets the applicable requirements for spouse or dependent coverage under the Plan and I agree to inform the Benefits Office if that changes while my election of coverage is in effect. I understand that I may change my elections only during Open Enrollment, for coverage effective the next January 1, or by requesting a permitted change within 31 days of a family status change. I attest that the information provided above is complete and true to the best of my knowledge. I understand that false information will result in claim denial and possible termination of eligibility for coverage.

Retiree Signature: _____ Date: _____
 **Return the completed form to Human Resources 5 Harry Truman Parkway, Annapolis, MD 21401 by October 31, 2023.

This form can be mailed, sent via Fax to 410-222-7188, or emailed to humanresources@aacpl.net

For HR Use Only: Effective Date – 1/1/2024

RX: _____ CIGNA: _____ HCBO: _____ Vision: _____